Driscoll Health Plan

Electronic Funds Transfer (EFT) Authorization Agreement

After completion, submit this request to DHPContracting@dchstx.org
A voided check (front and back) or Bank verification letter (dated within past 6 months with appropriate signature) is required to process this request.
Requests from non-contracted providers must come directly from the provider and are not accepted from a third party.

Request Reason	Effective Date
New _____ *Change _____ Cancel _____	
Provider Tax Identifier (TIN) or Employer Identifier (EIN)	**Provider National Provider Identifier (NPI)**
Provider Name	**Doing Business As (DBA) Name**
Provider Street Address	**Provider Telephone Number**
Provider City/State/ZIP Code	**Provider Email Address**
Financial Institution Name	**Financial Institution Telephone Number**
Financial Institution Street Address	**Type of Account**
Financial Institution City/State/Zip Code	**Legal Name on Account**
Financial Institution Routing Number	**Provider Account Number**
Requestor Name	**Requestor Email**
*** Additional Information Required for Change Request**	
Current Financial Institution Name	**Current Legal Name on Account**
Current Provider Account Number	**Current Financial Institution Routing Number**

Explanation of Payment (EOP) documents are sent electronically, and DHP-contracted providers may access copies from our Provider Portal. Please let us know if you would like paper copies of the EOP mailed to you.

YES, Paper EOP Requested _____

I/we hereby authorize Driscoll Health Plan (DHP) to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I/we understand that I/we am/are responsible for the validity of the information on this form. If DHP mistakenly deposits funds into my/our account, I/we authorize DHP to initiate the necessary debit entries, which will not exceed the total of the original amount credited for the current pay cycle.

I/we agree to comply with all requirements of DHP, and the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by DHP or its authorized affiliate(s) or subcontractor(s). I/we will continue to maintain the confidentiality of records and other information relating to clients covered by programs offered through DHP in accordance with applicable state and federal laws, rules, and regulations.

I/we understand that payment of claims will be made from federal and state funds, and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

_____ _____

Authorizing Signature Date Signed

_____ _____

Printed Name Title of Signatory