



Electronic Funds Transfer (EFT) Authorization Agreement

Provider Name	Doing Business As (DBA)
Provider Street Address	Provider City
Provider State/Province	Provider ZIP Code/Postal Code
Provider Tax Identifier (TIN) or Employer Identifier (EIN)	National Provider Identifier (NPI)
Assigning Authority Medicaid	Trading Partner ID
Provider Contact Name	Provider E-Mail Address
Provider Phone Number	Provider Fax Number
Financial Institution Name	Financial Institution Street Address
Financial Institution Telephone Number	Financial Institution City/State/Zip
Financial Institution Routing Number	Type of Account at Financial Institution
Provider's Account Number at Financial Institution	Provider Preference for Grouping Claim Payments
	<input type="checkbox"/> TIN or <input type="checkbox"/> NPI (Please <input checked="" type="checkbox"/> one)
Reason for Submission	
<input type="checkbox"/> NEW <input type="checkbox"/> CHANGE <input type="checkbox"/> CANCEL (Please <input checked="" type="checkbox"/> one)	

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 am (we are) responsible for the validity of the information on this form. If DHP erroneously deposits funds into my (our) account, I (we) authorize DHP to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay cycle.

I (we) agree to comply with all certification and credentialing 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) 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.

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.

Authorizing Signature	Date Signed
Printed Name	Title of Signatory

For the convenience of having direct deposit, you must be willing to download your EOB/EOP directly from the www.driscollhealthplan.com website. *No paper copies will be mailed.

RETURN THIS FORM ELECTRONICALLY OR MAIL

Driscoll Health Plan
 ATTN: EFT Enrollment Department
 4525 Ayers St Corpus Christi, TX 78415-1401
 Electronically to DHPContracting@dchstx.org
 Fax# 361-808-2182

***A voided check or bank letter is required to process the request**