

Authorization Agreement for Electronic Funds Transfer (EFT)

Request for Phoenix Health Plan (PHP) Request for Abrazo Advantage Health Plan (HMO)

Provider/Facility Name _____ Provider /Facility F# _____
 Provider/Facility Tax ID # _____ Provider/Facility AHCCCS ID # _____
 UPIN # _____ NPI# _____

I hereby authorize VHS Phoenix Health Plan, Inc. (PHP) and/or Abrazo Advantage Health Plan, Inc. (AAHP), its parent or subsidiary, (Plan) to initiate credit entries to our checking account indicated below at the depository financial institution named below, hereinafter called DEPOSITORY, to credit the same to such account.

Name on Account _____

Depository Name _____

Branch _____ City _____ State _____

Routing # _____ Account # _____

This authorization is to remain in full force and effect until Plan has received written notification of it's termination in such time and in such manner as to afford Plan and Depository a reasonable time to act on this information. Please allow 15 business days to **initiate** or to **cancel** direct deposit. This request authorizes Plan to stop payment or posting of, reverse or adjust any entry erroneously credited to this account.

Name _____ Title _____ Phone (____) _____
(Please Print)

Signed _____ E-mail _____

Date _____ Fax _____

Please attach a copy of voided check to a separate page when submitting it to be processed.
Forms presented without a copy of voided check will be returned to the requestor, unprocessed.

Please return completed form and copy of voided check on separate page via mail or fax to:

Mail: Attn: Network Management - EFT **Fax:** Attn: Network Management - EFT
 7878 North 16th Street, Suite 105 602-674-6670
 Phoenix, AZ 85020

You will be contacted by fax (if no fax# provided, then by email) when set up is complete.
 Please contact Network Management with questions at 602-824-3700

Attach a Copy of Your Voided Check on a Separate Page

INTERNAL USE ONLY

Option 1 Option 2 Vendor #: _____

Set Up Completed Date: _____ By: _____

EFT Effective Date: _____ Claims Processed Week of: _____ Paid Week of: _____

Confirmation Sent To Provider Date: _____ By: _____

Method Used To Notify: Fax E-mail _____