ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION FORM

The information concerning your organization's financial institution will be used to make electronic fund transfer payments on all invoices that are due and approved for payment for the legal business name listed below. Please note that EFT payments can be made to checking and savings accounts.

This form is for: ___ an initial request for EFT payments ___a change in an existing enrollment		
Provider Legal Business Name:		Federal Tax ID#:
Address:		
City:	State:	Zip Code:
Name and Title of Contact Person for Billing and Payments:		
Contact Person's Telephone:		Contact Person's E-Mail Address:
FINANCIAL INSTITUTION INFORMATION		
ABA (Transit Routing) Number:		
Bank Account Number:		
Name of Financial Institution:		Telephone:
Address:		
City:	State:	Zip Code:
Name on Checking Account:		
E-Mail for Remittance Payment Advice:		

AUTHORIZING SIGNATURE: By signing this document, you are authorizing EFT payments for ____________________________ to be sent to the above account.

PRINT NAME: ____________________________ SIGNATURE: ____________________________

TITLE: ____________________________ PHONE NUMBER: ____________________________

DATE SIGNED: ____________________________ FAX NUMBER: ____________________________

Please return this completed form to: Fallon.Suppliers@fallonhealth.org