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	**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** ◉ TIN ○ NPI
Reason for Submission ◉ NEW ○ CHANGE ○ CANCEL	

I (we) hereby authorize CountyCare 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 CountyCare erroneously deposits funds into my (our) account, I (we) authorize CountyCare 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 CountyCare and the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by CountyCare 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 CountyCare in accordance with applicable state and federal laws, rules, and regulations.

Authorizing Signature _____ **Date Signed** _____

Printed Name _____ **Title of Signatory** _____

EFT Set-Up requires either a copy of a blank check, OR a letter from your bank. Please be sure to submit one of these along with your completed form.

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

RETURN THIS FORM ELECTRONICALLY OR TO:

CountyCare

ATTN: EFT Enrollment Department
PO Box 3727 Corpus Christi, TX 78463
providerservices@countycare.com

*Forms must be mailed-in or scanned and sent by e-mail. Fax copies WILL NOT be accepted due to readability.