meridianhealth
A WellCare Company

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

PART I: REASON FOR SUBMISSION

Reason for Submission (check one):

New EFT Authorization | Change Existing EFT | Cancel EFT

PART II: PROVIDER OR SUPPLIER INFORMATION

Provider/Supplier Legal Business Name
Account Holder's Street Address

Account Holder's City	Account Holder's State	Account Holder's Zip

Tax Identification Number: (designate SSN or EIN)
National Provider Number (NPI)

PART III: FINANCIAL INSTITUTION INFORMATION

Financial Institution Name	
Financial Institution City/Town	Financial Institution State
Financial Institution Telephone Number	Financial Institution Contact Person
Name on Bank Account	Financial Institution Routing Transit Number (nine digit)
Depositor Account Number	Type of Account (check one) Checking Account Savings Account

Please include a confirmation of account information on bank letterhead or a voided check. When submitting the documentation, it should contain the name on the account, electronic routing transit number, account number and type. If submitting bank letterhead, the bank officer's name and signature is also required.

PART IV: PRIMARY CONTACT FOR ORGANIZATION

Contact Person's Name	Contact Person's Title
Contact Person's Telephone Number	Contact Person's Email Address

PART V: ELECTRONIC REMITTANCE ADVICE INFORMATION

EDI Value Added Network (VAN) / Clearinghouse	PGP Key (check one) Yes No
Contact Person's Name	Contact Person's Email Address
Contact Person's Telephone Number	EIN #

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

PART VI: AUTHORIZATION

I represent that I have the authority to enroll the provider identified in this form.

The organization identified above authorizes MeridianHealth (Meridian), through its designated financial institution, to make electronic payments to the checking account at the depository financial institution (depository) named above for services performed under the Participating Practitioner Agreement ("Agreement") between the organization identified above and Meridian and its affiliates. Such payments shall be made through the regional automated clearinghouse (ACH) associations, subject to the operating rules of the National Automated Clearinghouse Association. This authorization is ancillary to the Agreement and shall not be deemed to alter or amend any terms of the Agreement. This authorization is to remain in full force and effect until it is revoked. Revocation will be effective within a reasonable period following receipt of written notice by Meridian, which will be no later than thirty (30) days after receipt of written notice. Notice of revocation must be provided to Meridian at the address set forth below. Meridian may cease providing any or all of the EFT services upon notice to the Primary Contact named above. Revocation will not apply to transactions initiated before the effective date of such revocation. The practitioner identified above certifies that the above information is true and accurate in all respects and will promptly notify Meridian at the address listed below of any changes to the information on this form.

PART VII: SIGNATURE LINE

Authorized/Delegated Official Name (Print)	Authorized/Delegated Official Telephone Number
Authorized/Delegated Official Title	Authorized/Delegated Official Email Address
Authorized/Delegated Official Signature	Date

After completing the enrollment form, please return this form, along with a voided check or your account information on bank letterhead, to Meridian in one of the following ways:

1. Via secure fax to 313-202-0008
2. Scan and email to providerhelp.mi@mhplan.com
3. Mail to:

MeridianHealth
ATTN: Provider Services
1 Campus Martius, Suite 700
Detroit, MI 48226

Enrollments are processed within two weeks of receipt. Please keep a copy of the completed and signed enrollment form for your records.

If you have any questions or concerns please contact your local Provider Network Development Representative or the Provider Services department directly at 888-773-2647.