HEALTH CHOICE UTAH, INC.
ELECTRONIC FUNDS TRANSFER (EFT) FORM

Health Choice Utah, Inc.
PO Box 45900, Salt Lake City, UT 84145
Scan/Email Completed Form to Providers@HealthChoiceUtah.com

Transaction Type

New EFT Setup ☐ **Change Account Type** ☐ **Change Financial Information** ☐ **Cancellation** ☐

Send Paper EOB: Yes ☐ **No** ☐

PAYEE IDENTIFICATION

Required Attachment: Please include a copy of a voided check (Bank Letter for Deposit Only accounts) and W-9 Form.
Note: A separate form is required for each EIN. Enrollment for EFT is done on a per-TIN basis. Payments and/or remittance advices for all providers billing with the TIN below will be affected.

Payee Name (as it appears on Line 1 of W-9 Form): _____

Tax Identification Number (TIN): _____

Billing Address: _____

City: _____ **State:** _____ **Zip:** _____

EFT Contact Name: _____ **EFT Contact Phone:** _____

I hereby authorize Health Choice Utah on behalf of itself and its affiliates, (hereinafter "Company"), to initiate credit entries to the account(s) at the bank(s) listed below for all benefits payments. This agreement will remain in effect until I notify Company of the desire to cancel or change this service or until Company notifies me that this service has been terminated. I understand I must allow reasonable time for my instructions to be executed. If Company credits more money than the correct benefits amount to the account due to duplicate electronic funds transfers (where "duplicate" is defined as multiple electronic funds transfers received for the same services rendered, the same membership, and the same dates of service) or erroneous electronic funds transfers (where "erroneous" is defined as complete electronic funds transfers received in error), I authorize Company to withdraw the overpayment. I authorize and request the bank(s) listed above to accept any credit entries by Company to such account(s) and to credit the same to such account(s). This authorization remains in effect until I submit an updated EFT Form requesting a change or termination and until such time that Company has a reasonable opportunity to act on such request. If our depository information changes, I agree to submit an updated EFT Form to Health Choice Utah, Attn: Provider Services Department, PO Box 45900, Salt Lake City, UT 84145. The change revocation is effective on the day that Company processes the request. I understand Company may elect to mail paper checks and discontinue making electronic transfers to my account without advance notice. I certify that I have read and agree to comply with the above Company rules governing payments and electronic transfers as they exist on the date of my signature on this form or all subsequently adopted, amended, or repealed. I consent to, and agree to, comply with these rules even if they conflict with this EFT Form. I certify that I am authorized to contract for the entity receiving deposits, pursuant to the provider agreement between Payee and Company, and that all information provided herein is accurate.

Signature: _____ **Print Name and Title**: _____ **Date**: _____

FINANCIAL INSTITUTION

Bank Name: _____

Bank Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Checking ☐ **Savings** ☐ **Routing Number**: _____

Account Number: _____

FOR HEALTH CHOICE UTAH USE ONLY

Date Received: _____ **Processed By**: _____ **Date**: _____

Comments: _____