Electronic Funds Transfer (EFT) Authorization Agreement Form

Provider Information:

Provider Name: ____

Provider Address: Street: ____

City: ______________________________________ State: ________ Zip Code_____________

Provider Identifiers Information:

Provider Federal Tax Identification Number (TIN) or Employer Identifier Number (EIN) _________________________

National Provider Identifier (NPI): ___________________

Assigning Authority (Gateway Health Legacy Number):______________

Provider Contact Information:

Contact Name: _________________________ Title: ____________________________________

Telephone Number: ______________________ Contact Email Address: _______________________________

Financial Institution Information:

Financial Institution Name: ____

Financial Institution Address: Street: ____

City: ______________________________________ State: ________ Zip Code_____________

Contact Name: _________________________ Telephone Number: ______________________

Financial Institution Routing Number: ______________________________________

Type of Account at Financial Institution: ☐ Checking ☐ Savings

Provider Account Number with Financial Institution: ______________________________

Account Number Linkage to Provider Identifier: ☐ Provider Federal Tax Identification Number (TIN) _______________

☐ National Provider Identifier Number (NPI):_____________________

Submission Information:

Reason for Submission: ☐ *New Enrollment* ☐ *Change Enrollment* ☐ *Cancel Enrollment*

Include with Enrollment Submission: ☐ Voided Check ☐ Bank Letter

Authorized Signature:

Written Signature of Person Submitting Enrollment: ____

Printed Name of Person Submitting Enrollment: ____

Printed Title of Person Submitting Enrollment: ____

Submission Date:_____/____/______ Requested EFT Start/Change/Cancel Date:_____/____/______

EFT Legal Notice: The EFT Responsible Party represents that he or she is the individual responsible for establishing arrangements for the Provider(s) referenced above. The EFT Responsible Party hereby authorizes Gateway Health to each initiate electronic payments to the bank account identified therein. The EFT Responsible Party agrees contact Gateway Health to make and any all changes to the banking information

I___________________have read and understand the terms. I attest that I am the EFT Responsible Party for the Provider(s) selected.

Please email/fax/mail this information to:

Email:EFTAuthorizationform@gatewayhealthplan.com
System Administration Fax: 855-878-4167
Gateway Health Plan®
Four Gateway Tower
444 Liberty Avenue, Suite 2100
Pittsburgh, PA 15222

Legal Disclaimer: Provider assumes complete responsibility and liability for any inaccurate or incomplete information made in connection with the EFT process and all consequences and damages resulting from providing such inaccurate of incomplete information

Gateway Health

Instructions for completing the 'GATEWAY HEALTH® ELECTRONIC FUNDS TRANSFER (EFT) AGREEMENT FORM'

Provider Information:

- **Provider name** (DBA Name) – Complete legal name of institution, corporate entity, or practice as reported (on file) at Gateway Health®
- **Provider Address**
  - **Street** – The number and street name where the person or organization can be found
  - **City** – City associated with provider address field
  - **State** – Two Character Code State/Provinces/Region associated with provider address field
  - **Zip Code** – Postal Zone code associated with provider address field

Provider Identifiers Information

- **Provider Federal Tax Identification Number (TIN) or Employer Identifier Number (EIN)** – Provider TIN or EIN, as reported to the IRS, is used to identify a business entity.
- **National Provider Identifier Number (NPI)** – A health Insurance Portability and Accountability Act (HIPAA) standard. The NPI (10 digit number) is a unique identification number for covered healthcare providers. Covered healthcare providers and healthcare clearinghouses **MUST** use the NPI in the administrative and financial transactions adopted under HIPAA
- **Assigning Authority** - Gateway Health Legacy Number

Provider Contact Information

- **Contact Name** – Name of contact in provider office for handling EFT issues
- **Title** – Title associated with 'Contact Name' at provider's office for handling EFT issues
- **Telephone number** – Telephone number associated with Contact Name
- **Contact Email Address** - An electronic mail address associated with Contact name

Financial Institution Information

- **Financial institution name** – Official name of the provider's financial institution or qualifying depository that will receive the funds
- **Financial institution address**
  - **Street** – The number and street name where the financial institution can be found
  - **City** – City associated with financial institution address field
  - **State** – Two Character Code State/Provinces/Region associated with financial institution address field
  - **Zip Code** – Postal Zone code associated with financial institution address field
  - **Contact Name** – Name of contact at financial institution for handling EFT issues
  - **Telephone number** – Telephone number associated with 'Contact Name'
  - **Financial Institution Routing Number** – A 9-digit identifier of the financial institution where the provider maintains an account which payments can be deposited
  - **Type of Account at Financial Institution** – The type of account the provider will use to receive EFT payments, e.g., Checking, or Savings
  - **Provider Account Number with Financial Institution** – Providers account number at the financial institution to which EFT payments are deposited
  - **Account Number Linkage to Provider Identifier** – Provider preference for grouping (bulking) claim payments (must choose one);
    - Provider Federal Tax Identification Number (TIN)
    - National Provider Identifier Number (NPI)

Submission Information:

Indicate your reason for completing this form by checking the appropriate box:

- **Reason for Submission**
  - **New Enrollment -** Currently not receiving EFT from Gateway Health
  - **Change Enrollment -** Currently receiving EFT, updated to financial routing information needed
  - **Cancel Enrollment –** Discontinue EFT, return to paper checks
- **Included with Enrollment Submission – Must** submit at least one of the below documents with the enrollment
  - **Voided Check** – A voided check is attached to provide confirmation of Identification/Account Numbers
  - **Bank Letter –** A letter on the providers financial institution letterhead that formally certifies the accounting owners routing and account numbers

Authorized Signature

- **Written Signature of Person Submitting Enrollment** – A (usually cursive) rendering or a name unique to a particular person used as confirmation or authorization and identity
- **Printed Name of Person Submitting Enrollment** - The printed name of the particular person used as confirmation or authorization and identity (Must match **Written Signature of Person Submitting Enrollment)**
- **Printed Title of Person Submitting Enrollment** – The printed title of the person singing the form; may be used with electronic and paper based manual enrollment
- **Submission Date** – The date on which the enrollment was submitted
- **Requested EFT Start/Change/Cancel Date –** The date in which the requested action is to begin

EFT Legal Notice

- **Written Signature of Person responsible for EFT at Provider(s) office**

General Information

- Complete forms can be faxed to System Administration @ 855-878-4167
- Please type or print legibly
- Use only black or blue ink.
- Online form can be accessed @ **http://www.gatewayhealthplan.com/providers/forms-and-reference-materials**
- Before submitting this form, we encourage providers to contact their financial institution to confirm they can handle EFT transactions via PNC Bank with the required minimum CCD+ data elements needed for re-association of the payment and the ERA.
- For questions about the paper or electronic enrollment process, please contact Cheryl Kozub @ 412-255-7242.

Determine Status of EFT enrollment

- Please allow 4 weeks for the enrollment process. If after 4 weeks you do not start receiving EFT payments, you may contact Cheryl Kozub @ 412-255-7242.

Research Missing/Late files

- If EFT files that have not been received after 4 business days of receipt of the corresponding ERA file, you may contact Cheryl Kozub @ 412-255-7242