CENTRAL CALIFORNIA ALLIANCE FOR HEALTH

1600 Green Hills Road, Suite 101 • Scotts Valley, CA 95066-4981 • (831) 430-5500
950 East Blanco Road, Suite 101 • Salinas, CA 93901-4419 • (831) 755-6000
530 West 16th Street, Suite B • Merced, CA 95340-4710 • (209) 381-5300

FACSIMILE TRANSMITTAL SHEET

Date:

Time:

To: **ATTN: Oksana Chabanenko, Finance**

Company: **Central California Alliance for Health**

Fax Number: **(831) 430-5871**

Sender: _____

Sender Phone #: _____

Sender Fax #: _____

Pages including cover: ____

Notes/Comments:

EFT/ACH CREDIT AUTHORIZATION FORM

AUTHORIZATION AGREEMENT FOR ELECTRONIC PAYMENTS (ACH CREDITS)

I hereby authorize Santa Cruz, Monterey, and Merced Managed Medical Care commission, doing business as Central California Alliance for Health (herein after referred to as CCAH) to deposit any amounts owed by initiating credit entries to the account at the financial institution (herein after referred to as Bank) indicated below. Further, I authorize the Bank to accept and to credit entries indicated by CCAH to my accounts.

This authorization is to remain in full force and effect until CCAH and Bank have received written notice of its termination in such time and in such manner as to afford CCAH and Bank a reasonable opportunity to act on it.

All fields are required

PROVIDER INFORMATION

Provider Name		Provider Federal Tax Identification Number (TIN)	
Doing Business As Name (DBA)		National Provider Identifier (NPI)	
Provider Address - Street	City	State/Province	ZIP Code/ Postal Code
Provider Contact Name	Telephone Number ( )	Email Address	

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name			
Financial Institution Address - Street	City	State/Province	ZIP Code/Postal Code

Financial Institution Routing Number:

Type of Account at Financial Institution: ☐ Checking ☐ Savings

Provider's Account Number with Financial Institution:

Account Number Linkage to Provider Identifier: ☐ Provider Tax Identification Number (TIN) ☐ National Provider Identifier (NPI)

SUBMISSION INFORMATION

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

Include with Enrollment Submission: ☐ Voided Check ☐ Bank Letter

Please attach a voided check or a letter on bank letterhead that formally certifies the account owner's routing and account numbers. Your request will not be processed without one of these items included.

AUTHORIZED SIGNATURE

Written Signature of Person Submitting Enrollment	Submission Date

Please FAX completed applications to:
(831) 430-5871, ATTN: Oksana Chabanenko, Finance

For questions about this form, please contact:
(800) 700-3874 x2618