healthfirst

EFT/ERA Authorization Form

Rev. 11/17/06

Type of Transaction (please choose)

☐ Add ERA and EFT ☐ Change ERA ☐ Terminate ERA and EFT
☐ Change EFT

Physician Group Notes:

- You need only fill out one EFT/ERA Authorization form per Tax ID as long as all the providers in the group have the same bank account.
- Please attach a list of the provider IDs, at the payee entity level, for whom you wish the Authorization to apply

Provider/Physician Name (please print)

Healthfirst Provider ID Number **National Provider Identifier (NPI)** **Federal Employer Identification Number**

Provider Type (please choose one)

☐ Ancillary ☐ Hospital ☐ Physician ☐ Physician Group

I hereby authorize Healthfirst, hereafter called COMPANY, to initiate credit entries and if necessary, adjustments for any credit entries to one of the following accounts indicated below and the depository named below, hereafter called DEPOSITORY, to credit the same to such account.

Account Type (please choose one if you wish to participate in the EFT process)

☐ Checking ☐ Savings ☐ Demand Deposit ☐ Money Market

Account Name _____

Depository/Bank Name (please print) **Address** (please print)

City **State** **Zip** **Phone**

Routing Number **Account Number**

Please include a deposit slip/cancelled check if you wish to participate in EFT.

If you wish to participate in our **ERA** process, please identify which Clearing House you (or your vendor) are currently using. Please note that you or your vendor must use one of the clearing houses in order to participate in our ERA process.

☐ Emdeon I-UB92 ☐ Emdeon P-HCFA 1500 ☐ Other: Name_____

This authority is to remain in full force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on said notice of termination. Provider agrees that all ERA and/or EFT transactions will be conducted in accordance with company's policies and procedures (and may be changed from time to time) and may be suspended or discontinued at any time.

Special ERA/Paper Remittance Note

❍ I wish to receive ERA only.

Please note: At the conclusion of the grace period, paper remits will no longer be available.

Name (please print) Title

Signature Date

Please provide the name of a contact person that can verify and provide any changes in the above listed data.

Contact Name (please print) Title Phone Number Email Address

Address City State Zip

Please direct all questions to:
Phone: 888-801-1660

Completed forms can be submitted as follows:
Mail: Provider Services, P.O. Box 5168, New York, NY 10274-5168
E-Mail: ERAEFT confirmation@healthfirst.org or Fax: 646-313-4635
www.healthfirstny.com