
Direct Deposit Authorization for Electronic Funds Transfer (EFT)

- New EFT Authorization
- Revision to Current Authorization (i.e. account or bank changes)
- EFT Termination Request

Payee Information

Provider or Business Name _____

Provider License # _____

Provider Type _____

Provider Taxonomy Code _____

TIN or SSN (9 digits) _____

National Provider ID (NPI) (10 digits) _____

(List all if more than one provider's fund will be deposited to this account)

UHIN Trading Partner Number (HT#) OR Clearinghouse Name (If applicable)

Remittance type (check one): 835 Electronic Remittance Advice Web PDF file download

Contact Name _____ Contact Phone _____

Email Address _____
(Required if downloading the PDF remittance file from our website)

Billing Address _____

City _____ State _____ Zip Code _____

Physical Address (If different from billing address)

City _____ State _____ Zip Code _____

Depository Information (Financial Institution)

Account Holder Name _____

Depository Name _____

Street Address _____

City _____ State _____ Zip Code _____

Depository Contact Person _____

Depository Telephone Number _____

Depository Routing Transit Number (9 digits) _____

Depository Account Number _____

Type of Account (check one): Checking Account Savings Account

Please attach a letter of account verification from your bank. Do not attach a deposit slip as they do not contain sufficient information for processing.

Authorization for Setup

I hereby authorize Public Employees Health Program to initiate credit entries to the account number listed above. I further authorize Public Employees Health Program to correct credit entries made in error to this account. I agree that this **Authorization for Setup** is to remain in full force and effect until Public Employees Health Program has received written notification from me on its termination, in such time and manner as to afford the Public Employees Health Program Financial Institution a reasonable opportunity to act upon my notification. I recognize that if I fail to provide complete or accurate information on the above **Direct Deposit Authorization for Electronic Funds Transfers (EFT)**, the processing of this form may be delayed and/or my payments may be erroneously transferred. If funds are erroneously transferred due to my failure to provide complete or accurate information on this form, I hereby hold Public Employees Health Program harmless for the recovery of such erroneous transfers, notwithstanding any reasonable attempts made by Public Employees Health Program to correct such errors.

I the undersigned certify that I am authorized to provide the above information and the information is true and correct.

Name (Please print) _____ Date _____

Title (Please print) _____ Phone # _____

Authorized Signature _____

Please return the completed form using one of the following methods:

Message Center (Preferred)

Provider Portal available at www.pehp.org.

Mailbox name: *Web, Form Status & General*

Subject: *EFT Form Completed*

Mail

PEHP

Attn: EDI Department

560 East 200 South

Salt Lake City, UT 84102

If you have any questions, please call our EDI department at 801-366-7544 or 800-753-7818.
