EFT Enrollment Authorization Agreement

Please type directly into this form or print clearly. Please complete all required information. All * fields are required.

Provider Information

*Provider Name: _____

Provider Address (Remittance)

*Street: _____

*City: _____ *State/Province: _____ *Zip Code/Postal Code: _____

Provider Identifiers Information

*Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN): _____

National Provider Identifier (NPI): _____

Provider Contact Information

*Provider Contact Name: _____

*Telephone Number: _____

*Email Address: _____

Fax Number: _____

Financial Institution Information

*Financial Institution Name: _____

*Financial Institution Routing Number: _____

*Type of Account at Financial Institution: ☐ Checking ☐ Savings

*Provider's Account Number with Financial Institution: _____

Submission Information

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

Authorized Signature

Written signature of person submitting enrollment: Printed name of person submitting enrollment

_____

Fax to our secure fax line: (503) 574 – 8160

Note: This fax will be received securely by PHP Systems Administration Manager.