Provider Automatic Bank Payment
Electronic Funds Transfer Authorization Agreement

To set up automatic electronic funds transfer, please:

1. Complete, sign and date the authorization agreement form;
2. Provide a copy of a voided check (scanned copy if emailing) to ensure we have the correct banking information;

IMPORTANT: Automatic electronic funds transfers are only available to participating providers with Avera Health Plans. We will not process this form unless we have a completed Electronic Remittance Advice (835) form on file.

Please check one:

☐ Start electronic funds transfers (new enrollment), start date (MM/YY): _____ / _____
☐ Change existing electronic funds transfer enrollment

Provider Name (legal entity) _____ Tax Identification Number _____
Street Address _____ Contact Name _____
City _____ State _____ ZIP _____
Email Address _____ Phone Number (_____) _____
Group NPI(s) or Individual NPI(s) _____

BANKING INFORMATION

_____ (_____) _____
Financial Institution Name Phone Number

_____ _____ _____ _____
Financial Institution Street Address City State ZIP

_____
Name on Bank Account

Please provide your business checking account number below and **attach a voided check** showing your legal entity's name, preprinted account number and the name and address of your financial institution.

☐ Business Checking Account Number: _____

Routing/ABA Number: _____ _____ _____ _____ _____ _____ _____ _____ _____

NOTE: Checking account routing numbers are the nine digits printed on the bottom of check between these characters ⑆ ⑆. If you elected to use your savings account, please contact your financial institution to obtain proper routing number.

Authorization for Automatic Bank Payment Method

I hereby authorize Avera Health Plans to initiate automatic credit entries to the checking account at the financial institution listed above for all benefit payments. This agreement will remain in effect until Avera Health Plans is notified in writing to cancel or change this service or until Avera Health Plans notifies me this service has been terminated. I understand we must allow reasonable time for the request to be executed. I authorize and request the financial institution above to accept any credit entries by Avera Health Plans to such account and to credit the same to such account.

I hereby authorize Avera Health Plans to initiate debit entries in accordance by state law to initiate adjustments for any duplicate or erroneous entries made in error to the account indicated above. I hereby authorize the financial institution named above to credit and/or debit the same to such account. If an electronic debit is unsuccessful, or for deposit-only accounts, or not permitted by state law, Avera Health Plans will pursue settlement via alternate measures.

This Authorization Agreement must be signed by an authorized signer on the checking account referenced above.

By signing below, I certify that the above information is true and accurate to the best of my knowledge and that I have the authority to initiate the actions requested herein. I will promptly notify Avera Health Plans of any changes to the information on this form by submitting an updated Automatic Electronic Funds Transfer Authorization Agreement.

Printed Name _____ Title _____
Phone Number (_____) _____

_____ _____
Authorized Signature Date Signed

Please email completed form to: Providers@AveraHealthPlans.com or fax 605-322-4540
or mail to: Avera Health Plans Network Services, 5300 S. Broadband Ln., Sioux Falls, SD 57108-2221

If you have any questions, please contact our Service Center at 605-322-4545 or toll-free at 1-888-322-2115, 8 a.m. to 5 p.m. CT, Monday through Friday.