



Provider Electronic Remittance Advice and Automatic Bank Payment Electronic Funds Transfer Authorization Agreement

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

Please check one:

Form with checkboxes for 'New Enrollment for ERA and EFT' and 'Update Existing Information' with fields for start dates.

Practice Name (legal entity), Tax Identification Number, Billing Address, Contact Name, City, State, ZIP, Email Address, Phone Number, Billing NPI, Current Clearinghouse

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 or bank letter 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 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.

This Authorization Agreement must be signed by an authorized signer on the checking account referenced above and have the authorization to set up Electronic Remittance Advice.

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.

Printed Name _____ Title _____

Phone Number _____

Authorized Signature _____ Date Signed _____

Please email completed form to: Providers@AveraHealthPlans.com or mail to: Avera Health Plans 5300 S Broadband Ln, Sioux Falls, SD 57108 If you have any questions, please contact our Customer Care Team toll-free at 888-322-2115, 8 a.m. to 5 p.m. CT, Monday through Friday.