PLAN DE SALUD MENONITA

EFT ENROLLMENT FORM FOR PROVIDER

PROVIDER INFORMATION

Provider Name	
POSTAL ADDRESS	
City	**State** **Zip Code**
Contract Name	**Email Address**
Telephone	**Fax Number**
Tax ID Number	**Provider NPI Number**

FINANCIAL INSTITUTION INFORMATION

Nine Digits Routing Transit Number	
Account Number	
Account Name	
Type of Account	☐ Checking ☐ Savings
Bank Name	**Bank Branch**

I authorize Plan de Salud Menonita to make electronic credits to my accounts in the above specified financial institution.

SUBMISSION INFORMATION

Reason for Submission	☐ New ☐ Change
Authorized Signature	**Date (MM/DD/YYYY)**

THIS SECTION COMPLETED BY PROVIDER

Authorized Signature	**Date (MM/DD/YYYY)**

Plan de Salud Menonita has the right to adjust future payments or debit to the Provider account via ACH if payments previously made are found to be duplicated, in excess of requirements, fraudulent of in error.

Return this completed form to Plan de Salud Menonita via email to: provider_ach@planmenonita.com
PLEASE INCLUDE A VOIDED CHECK, BACK CERTIFICATION FORM OR DEPOSIT SLIP