



Instructions for Completing the EFT Authorization Form

Section 1: Reason for Submission

Indicate your reason for completing this form by checking the appropriate box and providing the date you filled out the form. If you are authorizing EFT payments on behalf of a provider or organization, you must include a letter from the provider or organization approving the authorization. The letter must be signed by an authorized official of the provider or organization

Section 2: Provider Information

Please provide the legal business name of the provider, as well as the account holder's street address, city, state, and zip code. You must also include the tax identification number as reported to the IRS and the 10-digit NPI of the provider.

Section 3: Financial Institution Information

Enter your financial institution's name; this is the name of the bank that will be receiving the funds. Please provide the street address, city, state, zip of your financial institution, as well as phone & fax numbers, email address of the financial institution, and a contact person's name.

Section 4: Contact Person

Provide the name, title, phone number, fax number, and email address of a contact person who can answer questions about the information submitted on the authorization form.

Section 5: Account Information

Please provide your account number and routing information of the account you want funds transferred to.

Section 6: Authorization

Sign the form certifying that the account is controlled by the physician and/or organization and will be the recipient of the electronic funds transfer. In addition, please provide the title, phone number and email address of the authorized official.



Electronic Funds Transfer (EFT) Authorization Form

Date: _____ Action Requested: New Setup Change to Current Setup Cancel Setup

Provider/Account Holder Information:

Provider Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Tax ID: _____ NPI: _____
Contact Name: _____ Phone: _____
Fax: _____ Email: _____

Financial Institution Information:

Financial Institution Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
Email: _____ Contact Person: _____

Primary Contact: _____
Title: _____ Phone: _____
Fax: _____ Email: _____

Account Information:

Financial Institution Routing Transit Number (nine digit): _____ Depositor Account Number: _____

Signature Line:

Authorized Official Name (Print): _____ Phone: _____
Title: _____ Email : _____
Signature: _____ Date: _____

Email or Mail Completed Form To:

Group Health Cooperative of South Central Wisconsin
Attention: Accounting Department
1265 John Q Hammons Drive
Madison, WI 53717
accounting@ghcscw.com