INSTRUCTIONS FOR COMPLETING THE EFT AUTHORIZATION FORM

Group Health Cooperative of South Central Wisconsin

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, check the Third-Party box and 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. If EFT setup is for multiple NPIs, please list those on page 3.

Section 3: Primary Contact

Provide the name, title, phone number, and email address of an authorized representative who can validate the banking information submitted on the authorization form.

Section 4: 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, phone number, email address of the financial institution and a contact person's name. Providers are responsible for contacting their financial institution to ensure the bank delivers the CORE-required Minimum CCD+ Data Elements needed to reassociate Electronic Funds Transfer (EFT) payments with the corresponding Electronic Remittance Advice (ERA/835). These data elements include the Effective Entry Date, Payment Amount, and Payment Related Information (including the EFT Trace Number).

Section 5: Account Information

Please provide your account number and routing information of the account you want funds transferred to. Indicate the bank account type. Include a copy of a voided check or a bank letter dated within the last 12 months.

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.

GHC-SCW will contact the email provided under Provider/Account Holder Information once EFT setups are complete. Turnaround time is 30 days.

If you require assistance, please email **eft@ghcscw.com**.

Group Health Cooperative
of South Central Wisconsin

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION FORM

Reason for Submission:

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

Provider/Account Holder Information:

☐ Third-Party Representative

Provider Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Tax ID: _____ NPI: _____

Primary Contact:

Name: _____ Phone: _____

Email: _____

Financial Institution Information:

Financial Institution Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Account Information:

Routing Number:

_ _ _ _ _ _ _ _ _

Account Type: ☐ Checking ☐ Savings

Account Number:

_____

Authorization:

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 Hammos Drive
Madison, WI 53717
eft@ghcscw.com

GHC-SCW will contact the email provided under Provider/Account Holder Information once EFT setups are complete. Turnaround time is 30 days.

Multiple NPIs: