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, 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.

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ELECTRONIC FUNDS TRANSFER (ETF) 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 Hammos Drive
Madison, WI 53717
accounting@ghcscw.com

For GHC Purposes Only:

Date Received: _____

Date Completed: _____