COMMUNITY HEALTH CENTER NETWORK

SIGN UP TODAY!

EFT stands for electronic funds transfer and represents the way your group can receive direct deposit payments from Community Health Center Network (CHCN)

All providers are eligible to receive payments by EFT!

HOW DO I SIGN-UP?

STEP 1

Complete the EFT Authorization Agreement form

STEP 2

Include with your form:

- A voided check or account information on a bank letterhead
- A current W-9

STEP 3

Submit EFT by:

- Fax to 510-297-0445 or
- Email to Provider Services

WHY SIGN-UP?

Faster Payments:

- Avoid waiting for your check and receive faster payments
- Streamlined payment process

Secured Payments:

- Payment will be directly deposited to your group's account
- No loss or stolen checks

EFT is better for the environment. Using less paper helps reduce our environmental footprint.

Contact Customer Care if you have any questions

chcncustomercare@chcnetwork.org

(510) 297-0200

COMMUNITY HEALTH CENTER NETWORK

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

PART I: REASON FOR SUBMISSION

Reason for Submission:

☐ New EFT Authorization

☐ Revision to Current Authorization

(e.g. account or bank changes)

☐ Check here if EFT payment is being made to the Home Office of Chain

(Attach letter Authorizing EFT payment to Chain Home Office)

Since your last EFT authorization agreement submission, have you had a:

☐ Change of Ownership, and/or

☐ Change of Practice Location?

If you checked either a change of ownership or change of practice location above, you must submit a change of information (using the Medicare enrollment application) to the Medicare contractor that services your geographical area(s) prior to or accompanying this EFT authorization agreement submission.

PART II: PROVIDER OR SUPPLIER INFORMATION

Provider/Supplier: Legal Business Name

Chain Organization Name or Home Office Legal Business Name (if different from Chain Organization Name)

Account Holder's Street Address

Account Holder's City	Account Holder's State	Account Holder's Zip Code

Tax Identification Number: (designate ☐ SSN or ☐ EIN)

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Medicare Identification Number (if issued)

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National Provider Identifier (NPI)

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PART III: FINANCIAL INSTITUTION INFORMATION

Financial Institution Name

Financial Institution City/Town	Financial Institution State
Financial Institution Telephone Number	Financial Institution Contact Person

Financial Institution Routing Transit Number (nine digits)

☐☐☐☐☐☐☐☐☐

Depositor Account Number	Type of Account (check one)
☐☐☐☐☐☐☐☐☐☐☐☐☐	☐ Checking Account ☐ Savings Account

Please include a confirmation of account information on bank letterhead or a voided check. When submitting the documentation, it should contain the name on the account, electronic routing transit number, account number and type. If submitting bank letterhead, the bank officer's name and signature is also required. This information will be used to verify your account number.

PART IV: CONTACT PERSON

Contact Person's Name	Contact Person's Title
Contact Person's Telephone Number	Contact Person's E-mail Address

PART V: AUTHORIZATION

I hereby authorize Community Health Center Network (CHCN) to initiate credit entries, and initiate adjustments for any duplicate or erroneous entries made in error to the account indicated above. I hereby authorize the financial institution/bank named above to credit and/or debit the same to such account.

If payment is being made to an account controlled by a Chain Home Office, the Provider of Services hereby acknowledges that payment to the Chain Office under these circumstances is still considered payment to the Provider, and the Provider authorizes the forwarding of payments to the Chain Home Office.

If the account is drawn in the Physician's or Individual Practitioner's Name, or the Legal Business Name of the Provider/ Supplier, the said Provider or Supplier certifies that he/she has sole control of the account referenced above, and certifies that all arrangements between the Financial Institution and the said Provider or Supplier are in accordance with all applicable regulations and instructions.

This authorization agreement is effective as of the signature date below and is to remain in full force and effect until CHCN has received written notification from me of its termination in such time and such manner as to afford CHCN and the Financial Institution a reasonable opportunity to act on it. CHCN will continue to send the direct deposit to the Financial Institution indicated above until notified to change the Financial Institution receiving the direct deposit. If the Financial Institution information changes, I agree to submit to CHCN an updated EFT Authorization Agreement.

SIGNATURE LINE

Authorized/Delegated Official Name (Print)	Authorized/Delegated Official Telephone Number
Authorized/Delegated Official Title	Authorized/Delegated Official E-mail Address
Authorized/Delegated Official Signature *(Note: Must be original signature in black or blue ink.)*	Date

INSTRUCTIONS FOR COMPLETING THE EFT AUTHORIZATION AGREEMENT

Please submit the form to CHCN Provider Services department via email or fax at providerservices@chcnetwork.org or 510-297-0445.

All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any direct deposits are made.

PART I: REASON FOR SUBMISSION

Indicate your reason for completing this form by checking the appropriate box: New EFT authorization or change to your account information. If you are authorizing EFT payments to the home office of a chain organization of which you are a member, you must attach a letter authorizing the contractor to make payment due the provider of service to the account maintained by the home office of the chain organization. The letter must be signed by an authorized official of the provider of service and an authorized official of the chain home office.

PART II: PROVIDER OR SUPPLIER INFORMATION

Line 1: Enter the provider's/supplier's legal business name or the name of the physician or individual practitioner, as reported to the Internal Revenue Service (IRS). The account to which EFT payments made must exclusively bear the name of the physician or individual practitioner, or the legal business name of the person or entity enrolled with Medi-Cal.

Line 2: Enter the chain organization's name or the home office legal business name if different from the chain organization name.

Line 3: Enter the account holder's street address.

Line 4: Enter the account holder's city, state, and zip code.

Line 5: Enter the tax identification number as reported to the IRS. If the business is a corporation, provide the Federal employer identification number, otherwise provide your Social Security Number.

Line 6: If issued, enter the Medicare identification number assigned by a Medicare fee-for-service contractor. If you are not enrolled in Medicare, leave this field blank.

Line 7: Enter the 10 digit NPI number. The NPI is required to process this form.

PART III: FINANCIAL INSTITUTION INFORMATION

Line 8: Enter your Financial Institution's name (this is the name of the bank or qualifying depository that will receive the funds). Note: The account name to which EFT payments will be paid is to the name submitted on Part II of this form.

Line 9: Enter the city or town where your financial institution is located. Enter the state where your financial institution is located.

Line 10: Enter the bank or financial institutional telephone number and contact person's name.

Line 11: Enter the bank or financial institutional nine-digit routing number, including applicable leading zeros.

Line 12: Enter the depositor's account number, including applicable leading zeros. Select the account type.

If you do not submit this information, your EFT authorization agreement will be returned without further processing.

PART IV: CONTACT PERSON

Line 13: Enter the name and title of a contact person who can answer questions about the information submitted on this form.

Line 14: Enter the contact person's telephone number. Enter the contact person's e-mail address.

PART V: AUTHORIZATION

Line 15: By your signature on this form you are certifying that the account is drawn in the Name of the Physician or Individual Practitioner, or the Legal Business Name of the Provider or Supplier. The Provider or Supplier has sole control of the account to which EFT deposits are made in accordance with all applicable regulations and instructions. All arrangements between the Financial Institution and the said Provider or Supplier are in accordance with all applicable regulations and instructions with the effective date of the EFT authorization. You must notify CHCN regarding any changes in the account in sufficient time to allow the contractor and the Financial Institution to act on the changes.

The EFT authorization form must be signed and dated by the same Authorized Representative or a Delegated Official named on the CHCN enrollment application on file. Include a telephone number where the Authorized Representative or Delegated Official can be contacted.