MAGNACARE℠

Electronic Funds Transfer (EFT) Authorization Agreement

THIS ERA AUTHORIZATION AGREEMENT FORM MUST BE FULLY COMPLETED, SIGNED AND RETURNED VIA FAX (516.723.7397) OR EMAIL (EDIENROLLMENT@MAGNACARE.COM).

Reason for Submission (select one) New Enrollment Change Enrollment Cancel Enrollment

Include with Enrollment Submission Voided Check Bank Letter

Provider Information

Provider Type Physician Physician Group Ancillary Hospital

Provider Name ______________________________

Provider Street Address ______________________________

City ______________ State ______________ Zip Code ______________

Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) ______________

National Provider Identifier (NPI) ______________________________

Provider Contact Name ______________ Phone Number ______________

Email Address ______________ Fax ______________

Financial Institution Name ______________________________

ABA Routing Number ______________ Account Number ______________

Type of Account Checking Savings

Preference for Account Number Linkage to data is Federal Tax Identification Number (TIN).

Authorized Signature of Person Submitting Enrollment

Provider expressly authorizes MagnaCare to credit entries (or, if necessary, debit entries and adjustments for any credit entries made in error) to the above-referenced Bank Account number. Provider accepts responsibility for any resulting loss of payment and releases MagnaCare from any liability for or arising from Provider's failure to submit accurate or updated information to MagnaCare relating to the Bank Account. This authorization is to remain in effect until written notice in the form of an EFT cancellation or change is submitted to MagnaCare. The termination or change shall be effective 10 days subsequent to MagnaCare receipt of the updated form.

Printed Name ______________ Printed Title ______________

Requested EFT Start/Change/Cancel Date ______________ Submission Date ______________

Sign Here ______________________________

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Instructions for Completing MagnaCare Electronic Funds Transfer (EFT) Enrollment Form

- THIS ERA AUTHORIZATION AGREEMENT FORM MUST BE FULLY COMPLETED, SIGNED AND RETURNED VIA FAX (516.723.7397) OR EMAIL (EDIENROLLMENT@MAGNACARE.COM).
- For questions about this form or the electronic enrollment process, please contact the EDI Team. The EDI support team will contact you upon receipt of the completed EFT Enrollment Form.

Form Submission Fields Summary

SUBMISSION INFORMATION - Please select one.

- New Enrollment – Please include a copy of voided check if checking account is being used.
- Change Enrollment – Select when transitioning to a new bank account.
- Cancel Enrollment – Terminate EFT payments.

PROVIDER INFORMATION

Please complete all fields using the legal name, address & contact information of the institution, corporate entity, practice or individual provider.

PROVIDER IDENTIFIERS

- National Provider Identifier (NPI) - A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number).

- Provider Federal Tax Identification Number (TIN) - A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), used to identify a business entity.

PROVIDER CONTACT INFORMATION

Please complete all fields. Submit name and contact information for the person who is responsible for handling EFT issues.

PROVIDER'S FINANCIAL INSTITUTION INFORMATION

Please complete all fields. Enter the name of the financial institution, ABA routing number, provider account number and type of account. Preference for Account Number Linkage to data is Federal Tax Identification Number (TIN).

AUTHORIZED SIGNATURE

Signature of the person submitting enrollment. Please complete all fields.

Important Notice

The provider must contact its financial institution to arrange for the delivery of CORE required minimum CCD+ data elements needed for reassociation of the payment and the ERA. See Phase III CORE EFT & ERA Reassociation (CCD+/835) Rule Version 3.0.0.

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