



### EFT ENROLLMENT FORM FOR PROVIDER

PROVIDER INFORMATION	
Provider Name	
Address	
City / State / Zip Code	
Contract Name	Email Address
Telephone	Fax Number
Tax ID Number	Provider NPI Number

FINANCIAL INSTITUTION INFORMATION									
Nine Digits Routing Transit Number									
Account Number									
Account Name									
Type of Account <span style="margin-left: 100px;"><input type="checkbox"/> Checking</span> <span style="margin-left: 100px;"><input type="checkbox"/> Savings</span>									
Bank Name					Bank Branch				

I authorize Plan de Salud Menonita to make electronic credits to my accounts in the above specified financial institution.

SUBMISSION INFORMATION	
Reason for Submission <span style="margin-left: 100px;"><input type="checkbox"/> New</span> <span style="margin-left: 100px;"><input type="checkbox"/> Change</span>	
Authorized Signature	Date (MM/DD/YYYY)

THIS SECTION COMPLETED BY PROVIDER	
Authorized Signature	Date (MM/DD/YYYY)

Plan de Salud Menonita has the right to adjust future payments or debit to the provider's account via ACH if payments previously made are found to be duplicated, in excess of requirements, fraudulent or in error.

**Return this completed form to Plan de Salud Menonita via email to: [provider\\_vital\\_ach@planmenonita.com](mailto:provider_vital_ach@planmenonita.com)  
Please include a voided check or deposit slip**