Electronic Funds Transfer (EFT) Authorization Form

Provider Name: _____

Provider Address: _____

Provider City, State, Zip: _____

Provider Federal Tax Identification Number (or SSN): _____

Bank Name: _____

Bank Address: _____City: _____ State: _____ Zip_____

Routing Number: _____ Account Number: _____
(9 digits)

☐ Checking Account ☐ Savings Account

By signing below, I hereby authorize Care Wisconsin, Inc./Care Wisconsin Health Plan, Inc. to deposit claim funds to my account indicated above at the depository financial institution named above. I acknowledge that the origination of Automated Clearing House (ACH) transactions must comply with the provisions of U.S. law. Claim payments will be made after the claim has been adjudicated by our claims processor. I further acknowledge that I will no longer receive a paper remittance advice, but must retrieve them electronically for payment reconciliation. This authorization is to remain in full force and effect until Care Wisconsin, Inc./Care Wisconsin Health Plan, Inc. has received written notification from me of its termination in such time and in such manner as to afford Care Wisconsin, Inc./Care Wisconsin Health Plan, Inc. and the financial institution indicated above, a reasonable opportunity to act on it. I certify that the information provided is true and accurate in all respects and that I have been duly authorized to perform transactions on this account.

Authorized by: _____ Phone: _____
(Print Name and Title)

Authorized Signature: _____ Date: _____

~REMEMBER TO ATTACH A VOIDED CHECK FOR CHECKING ACCOUNTS OR A DEPOSIT SLIP FOR SAVINGS ACCOUNTS ~

FAX to: 608-245-3340

or scan and E-mail to: Provider-Help-Desk@carewisc.org

Care Wisconsin Use Only:

Reviewed and approved by: _____ Date: _____

Confirmed With: _____ Date: _____

Revision – 10/01/2014

Electronic Funds Transfer (EFT) Fact Sheet

Automatic payment is a voluntary service that Care Wisconsin, Inc. and Care Wisconsin Health Plan, Inc. offer to help with your claim payments. To sign up for the service, complete this form and return it with a voided check for checking accounts, or a deposit slip for savings accounts. Please allow 30 days processing time for EFT to begin.

Features:

- We will automatically deposit your claim payments to your bank account.
- Your provider remittance advice will only be available electronically via the HIPAA 835 transaction when you submit your claims using the HIPAA 837 transactions.
- When you submit a claim on paper, via spreadsheet, or electronically using the Claims Web Portal, your provider remittance advice will only be available on the Claims Web Portal.
- You can start or end the service at any time.

Benefits:

- Quick, Easy, Convenient.
- Free service.
- Ability to access your remittance advice electronically.

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