Please fill out form and fax to Provider Relations at 915-225-6762

Questions/Concerns call 915-532-3778 x1507

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH CREDITS)

Provider/Group Name: ____

NPI Number: ____

Tax ID Number: ____

I (we) hereby authorize:

El Paso Health to initiate credit entries to my (our) Checking Account/Savings Account (select one) indicated below at the depository financial institution named below, hereafter-called DEPOSITORY, and to credit the same to such account. I (we) acknowledge that the origination of ACH transaction to my (our) account must comply with the provisions of the U.S. law.

Depository Name: ____

Branch: ____

City: ____

State: ______________________________ Zip code: ______________________________

Account number: ____

Routing number: ____

This authorization is to remain in full force and effect until El Paso Health has received written notification from me (or either of us) of its termination in such time and in such manner as to afford El Paso Health and DEPOSITORY a reasonable opportunity to act on it.

Would you like to receive paperless Remittance Advice accessible through our web portal?

☐ **Yes** **Paperless Only**

☐ **No** **Continue to receive paper Remittance Advice**

Name(s): ____

Title: ____

Date: ____

Signature: ____

NOTE: CREDIT AUTHORIZATION MUST PROVIDE THAT THE RECEIVER MAY REVOKE THE AUTHORIZATION ONLY BY NOTIFYING THE ORIGINATOR IN THE MANNER SPECIFIED IN THE AUTHORIZATION.

ATTACH A VOIDED CHECK