AmeriHealth

Electronic Funds Transfer Enrollment Form – For participating providers

This Electronic Funds Transfer (EFT) Enrollment Form is for providers who are participating in the AmeriHealth HMO, Inc. and AmeriHealth Company of New Jersey (collectively, AmeriHealth) network.

Provider information		
Provider name:		
Provider's address Street address:		
City:	State:	ZIP:
Provider identifiers		
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):		
National Provider Identifier (NPI):		
Provider contact information		
Provider's contact name:		
Title:		
Telephone number:	Ext:	
Email address:		
Financial institution information		
Financial institution name:		
Street address:		
City:	State:	ZIP:
Financial institution's telephone number:	Ext:	
Financial institution's routing number:		
Type of account at financial institution: ☐ Checking:	☐ Savings:	
Provider's account number with financial institution:		
Account number linkage to provider identifier *(select and provide number from one of the two below)* ☐ Provider's Tax Identification Number (TIN):		
☐ National Provider Identification Number (NPI):		

Submission information

Reason for submission: (*check the appropriate box for your reason of submission*)

- ☐ **New enrollment:** Select if you do not currently receive EFTs from us and need to add a bank account.
- ☐ **Change enrollment:** Select if you already receive EFTs from us and need to update your bank account.
- ☐ **Cancel enrollment:** Select if you already receive EFTs from us and need wished to be cancelled.

Include with EFT enrollment submission: (*check the appropriate box for method of submission verification*)

- ☐ **Voided check:** A voided check is attached to provide confirmation of identification/account numbers.

OR

- ☐ **Bank letter:** A letter on bank letterhead that formally certifies the account owners routing and account numbers.

Authorized signature

The signature of an individual authorized by the provider or its agent to initiate, modify, or terminate an enrollment. This may be used with electronic and paper-based manual enrollment.

By signing and dating below, I, the appropriate designated representative of the provider noted here, attest that the information provided is accurate and complete.

Signature:

Printed name:

Title:

Submission date (MM/DD/YYYY):*

Requested EFT start/change/cancel date (MM/DD/YYYY):*

**Please note you will need a complete separate EFT Form for each provider NPI and TIN combination you have with AmeriHealth.*

Additional information

Attach this completed Electronic Funds Transfer Enrollment Form along with a **voided check** or **bank letter** to our online Provider eBusiness Inquiry form for AmeriHealth New Jersey and AmeriHealth Pennsylvania.

A member of our Provider eBusiness team will contact you within three business days to ensure that all required information was submitted on the form. Once AmeriHealth receives all necessary information, your request will be completed within 30 calendar days. A Provider eBusiness analyst will monitor your request and send confirmation to the email address provided on this form once your EFT request is completed.

If you have questions or need help completing this form, contact our Provider eBusiness team through our online Provider eBusiness Inquiry form for AmeriHealth New Jersey and AmeriHealth Pennsylvania.