GEISINGER HEALTH PLAN®

Electronic Funds Transfer Enrollment Form

Please complete form in its entirety and fax to (570) 214-1553

***Provider Information*:**
(1 form for each provider identification number)

Provider Name (Group):

_____
(Must be identical to name on bank account)

Provider Address (Primary Service):

Street _____

City _____ State/Province _____

ZIP Code/Postal Code _____

Provider Address (Primary Billing)

Street _____

City _____ State/Province _____

ZIP Code/Postal Code _____

Provider Identifiers Information

Provider Identifiers:
Provider Federal Tax Identification Number (TIN) or
Employer Identification Number (EIN): _____
(Must be the same as on file with Health Plan)

National Provider Identifier (NPI): _____ (Required when provider has been enumerated with an NPI)

Provider Contact Information

Provider Contact Name:

Telephone Number:

Email Address:

Fax Number:

Please continue on page 2. Complete form in its entirety and fax to (570) 214-1553

Financial Institution Information:

Financial Institution Name: _____

Financial Institution Address:

Street _____

City _____ State/Province _____

ZIP Code/Postal Code _____

Financial Institution Routing Number (9 digits found on check, NOT deposit slip): __ __ __ __ __ __ __ __ __

Type of Account at Financial Institution: ☐ Checking ☐ Savings

Provider's Account Number with Financial Institution: _____

Account Number Linkage to Provider Identifier:
Provider Tax Identifier Number (TIN) _____

Submission Information

Reason for Submission:

☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

Authorization Agreement for Direct Deposit of Provider Payments. Please read and sign your name below.
I hereby authorize Geisinger Health Plan, on behalf of itself and its affiliates, to initiate credit entries to the account at the bank listed above for all applicable provider payments. This agreement will remain in effect until I notify Geisinger Health Plan of the desire to cancel or change this service or until Geisinger Health Plan notifies me that this service has been terminated. I agree to provide notification of change/termination 30 days in advance. I understand that I must allow reasonable time for my instructions to be executed. I authorize and request the bank listed above to accept any credit entries by Geisinger Health Plan to such account and to credit the same to such account.

By signing below, I hereby agree that I have read and agree to the terms and conditions stated above.

Authorized Signature**:**

_____
Written Signature of Person Submitting Enrollment

_____ _____
Printed Name of Person Submitting Enrollment Submission Date

For Health Plan Use Only

Date Received:_____ Optional: Cdip #:_____ Office #:_____