Electronic Fund Transfer Form

Martin's Point Health Care

Direct Deposit/Electronic Fund Transfer (EFT) services are available to Martin's Point Generations Advantage and US Family Health Plan network providers who have signed up to receive Electronic Remittance Advices (ERAs/835s). Please read the instructions on the accompanying page prior to completing the form.

HEALTH CARE PROFESSIONAL OR FACILITY INFORMATION

Legal Entity Name:

Tax Identification Number:

Billing Address *(Street, City, State, Zip Code):*

Contact Name:

Telephone Number:

Email Address:

EFT REQUEST INFORMATION

Please include a voided check or specification sheet as requested in the instructions. Your application cannot be processed without this information. A voided deposit ticket is not acceptable.

Request Type (Check one): ☐ Cancellation ☐ Enrollment ☐ Change

BANK ACCOUNT INFORMATION

NPI Number*:

Bank Account Number:

Bank Routing Number:

Bank Account Name:

Type of Account (Check one):

☐ Business Checking ☐ Business Savings ☐ Other (personal, etc.)

Bank Name:

Bank Address *(Street, City, State, Zip Code):*

*Please enter the banking information associated with the NPI above. If you have additional NPI(s), please enter on the following page of this form if they differ from the information that was entered into the Bank Account Information section above.

AUTHORIZATION

Authorization is hereby granted for Martin's Point Health Care to credit said account at the financial institution named above for the purpose of transferring Martin's Point Health Care payments. Martin's Point Health Care is also granted authorization to correct inadvertent duplicate payment information. This authorization is to remain in effect until notification is given to Martin's Point Health Care in writing (with advance notice of at least ten (10) business days) on a Martin's Point Health Care Electronic Fund Transfer Form advising us of a change, and allowing reasonable time to implement such change.

Authorization Signature:

Printed Name:

Date:

Electronic Claim Submission: Electronic claim submission allows for quicker processing and payments. We offer three Electronic Data Interchange (EDI) options. Contact them directly to register for electronic claim submission to Martin's Point.

Please indicate which clearing house you use below:

☐ **Change Healthcare:** 1-800-845-6592, Martin's Point Payor ID: 53275

☐ **Office Ally:** 1-866-575-4120, Martin's Point Payor ID: MPHC1

☐ **Relay Health:** New users call 1-866-735-2963. Current users call 1-800-527-8133 to add Martin's Point Payor ID: MPHC2

Electronic Fund Transfer Form Instructions

Martin's Point Health Care

1) **Contact your claims clearing house directly to request Electronic Remittance Advices (ERA/835 files).** We offer three Electronic Data Interchange (EDI/clearing house) partners:
   - **Emdeon Business Services**: 1-800-845-6592, Martin's Point Payor ID: 53275
   - **Office Ally**: 1-866-575-4120, Martin's Point Payor ID: MPHC1
   - **Relay Health**: New users call 1-866-735-2963, Current users call 1-800-527-8133 to add Martin's Point Payor ID: MPHC2
2) **After you have received your first 835 file, please complete and submit this form to request Direct Deposit/Electronic Fund Transfer (EFT) service, or to change or cancel that service.** If changes are made to a Bank Account (e.g., financial institution or a new account number), another application must be submitted to Martin's Point Health Care.
3) **To ensure legibility, please type or clearly print all requested information.**
4) **Health Care Professional Name:** Please use the full name of the health care professional or facility. This name must match the legal entity associated with the TIN (Tax Identification Number). Only one authorization form should be completed for each TIN.
5) **Tax Identification Number:** Please provide the nine-digit number associated with the legal entity.
6) **Health Care Professional's Billing Address:** Mailing address (street or PO box), city, state and zip code.
7) **Contact Name:** Please provide the name of the individual who should be contacted if this form is incomplete or requires additional information.
8) **Telephone Number and Email Address:** Please provide the telephone number and email address of the Contact Person.
9) **IMPORTANT INFORMATION:** A voided check for the account(s) or a MICR-encoded specification sheet (which can be obtained from your bank) must be included with this authorization form. A voided deposit ticket is not acceptable.
10) **Funds can be electronically credited to any commercial account if the financial institution is a member of an Automated Clearing House (ACH).** You can confirm this by contacting your bank.
11) **Bank Account Information:**
    - **Bank Account Number:** The account number to which direct deposits from Martin's Point Health Care will be made.
    - **Bank Transit/Routing Number:** The nine-digit number that identifies your bank—usually found in the lower left corner of your check. Verify with your bank.
    - **Bank Account Name:** Practitioner, group, or business name associated with the bank account number.
    - **Bank Name:** The full name of your financial institution (e.g. Your Bank, N.A.).
    - **Bank Address:** The street address, city, state and zip code for your bank.
12) **Sign and date the form.**
13) **Retain a copy for your records. Fax or mail a copy to:**

    Martin's Point Health Care
    PO Box 9746, Portland, ME 04104
    Fax: 207-828-7834
    mcahelpdesk@martinspoint.org

14) **Please list the NPI numbers associated with the submitted EFT request.**

NPI #:	Bank Name	Bank Account #	Bank Routing #

Note: If the banking information for any of the NPI(s) listed above is different from what was entered into the Bank Account Information section on the first page of the EFT form, please enter the banking information associated with the NPI.