ELECTRONIC FUNDS TRANSFER PeakHealth **AUTHORIZATION FORM**

The information concerning your organization's financial institution will be used to make electronic fund transfer (EFT) payments on all claims that are due and approved for payment for the legal business name listed below.

This form is for: ☐ **an initial request for EFT payments** ☐ **a change in an existing enrollment**

Would you like to be enrolled in ERA (electronic remittance advice): ☐ **yes** ☐ **no**

Provider Legal Business Name:	Federal Tax ID #:	
Address:		
City:	State:	Zip Code:
Name and Title of Contact Person for Billing and Payments:		
Contact Person's Telephone:	Contact Person's E-Mail Address:	

FINANCIAL INSTITUTION INFORMATION

ABA (Transit Routing) Number:	Checking Account Number:	
Name of Financial Institution:	Telephone:	
Address:		
City:	State:	Zip Code:
Name on Checking Account:		

A COMPLETE FORM W-9 AND AN ORIGINAL VOIDED CHECK MUST BE RETURNED WITH THIS FORM.

AUTHORIZING SIGNATURE: By signing this document, you are authorizing EFT payment for Peak Health, LLC to be sent to the above account.

PRINT NAME: _____ SIGNATURE: _____

TITLE: _____ PHONE NUMBER: _____

DATE SIGNED: _____ FAX NUMBER: _____

Please return this completed form to:
Peak Health, LLC
Attn: Provider Relations
16 Sterling Drive Suite 102
Bridgeport WV 26330-9133

OR

Email to: Peakprovider@peakhealth.org