



# EFT/ERA Authorization Form

Rev. 11/17/06

**Type of Transaction** (please choose)

- Add ERA and EFT     Change ERA     Terminate ERA and EFT  
 Change EFT

**Physician Group Notes:**

- You need only fill out one EFT/ERA Authorization form per Tax ID as long as all the providers in the group have the same bank account.
- Please attach a list of the provider IDs, at the payee entity level, for whom you wish the Authorization to apply

\_\_\_\_\_  
**Provider/Physician Name** (please print)

\_\_\_\_\_  
**Healthfirst Provider ID Number    National Provider Identifier (NPI)    Federal Employer Identification Number**

**Provider Type** (please choose one)

- Ancillary     Hospital     Physician     Physician Group

I hereby authorize Healthfirst, hereafter called COMPANY, to initiate credit entries and if necessary, adjustments for any credit entries to one of the following accounts indicated below and the depository named below, hereafter called DEPOSITORY, to credit the same to such account.

**Account Type** (please choose one if you wish to participate in the EFT process)

- Checking     Savings     Demand Deposit     Money Market

\_\_\_\_\_  
**Account Name**

\_\_\_\_\_  
**Depository/Bank Name** (please print)

\_\_\_\_\_  
**Address** (please print)

\_\_\_\_\_  
**City**

\_\_\_\_\_  
**State**

\_\_\_\_\_  
**Zip**

\_\_\_\_\_  
**Phone**

Please include a deposit slip/cancelled check if you wish to participate in EFT.

\_\_\_\_\_  
**Routing Number**

\_\_\_\_\_  
**Account Number**

If you wish to participate in our **ERA** process, please identify which Clearing House you (or your vendor) are currently using. Please note that you or your vendor must use one of the clearing houses in order to participate in our ERA process.

- Emdeon I-UB92     Emdeon P-HCFA 1500     Other: Name \_\_\_\_\_

This authority is to remain in full force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on said notice of termination. Provider agrees that all ERA and/or EFT transactions will be conducted in accordance with company's policies and procedures (and may be changed from time to time) and may be suspended or discontinued at any time.

**Special ERA/Paper Remittance Note**

- I wish to receive ERA only.

Please note: At the conclusion of the grace period, paper remits will no longer be available.

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Please provide the name of a contact person that can verify and provide any changes in the above listed data.**

\_\_\_\_\_  
Contact Name (please print)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

**Please direct all questions to:  
Phone: 888-801-1660**

**Completed forms can be submitted as follows:  
Mail: Provider Services, P.O. Box 5168, New York, NY 10274-5168  
E-Mail: ERAEFT confirmation@healthfirst.org or Fax: 646-313-4635  
www.healthfirstny.com**