COMMUNITY HEALTH PLAN of Washington™

Electronic Funds Transfer (EFT) Form

This form may be used to enroll in EFT.
Community Health Plan of Washington can issue EFT's to all healthcare provider types, including those receiving capitation.

Use the following guide when completing your EFT form. Fields with an asterisk (*) are required; sections left blank or illegible will delay processing.

- ☐ Complete the EFT form and email to DS.CHPW.prov.maint@nttdata.com OR mail to Community Health Plan of Washington PO Box 269002 Plano, TX 75026-9002 along with a pre-printed voided check that has the account holder name imprinted on the check or bank letter (deposit slips, starter checks, handwritten or altered checks are not accepted).
  - Email enrollment status inquires to DS.CHPW.prov.maint@nttdata.com
- ☐ Include your billing NPI (NPI receiving payment) on the enrollment form.
  Note: If you DO NOT want all claims processed under this TIN set up for EFT, please choose from one of the following options:
  - NPI Level Setup – EFTs will only be transmitted for the billing NPIs that are enrolled. Be sure to list the two or more NPIs you would like to enroll.
  - Billing Address Level Setup – EFTs will be transmitted based on the specific billing address(s) enrolled only. Please list the billing address(s) you would like to enroll.
- ☐ The EFT form must be signed by an authorized healthcare individual. The signing authority must match the legal entity associated with the tax ID. *e.g. Practitioner (MD, DO, DC, DDS, PhD, etc.) or Corporate Officer/Authorized Manager (CEO, CFO, Office Manager, etc.)*
- ☐ **IMPORTANT -** Please allow 15 business days for processing. Processing times may vary depending on the number of enrollments received and the accuracy of information provided. An email confirmation will be sent letting you know when your EFT will start.
- ☐ Once we transmit an EFT to your bank, your bank has 3 business days to settle the funds and make them available in your account. Claims already in process on or before your effective date will still generate paper checks. Note: your bank must be a participating member of the Automated Clearinghouse Association (ACH)
- ☐ You must contact your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Data Elements necessary for successful reassociation of the EFT payment with the ERA.
- ☐ If you are requesting EFT for your capitated payments, you must be set up for capitation. Once EFT is effective, all medical claims and capitated payments will be made via EFT.
- ☐ EFT email notifications are sent when EFT is active and a claim has been processed and payment has been issued.
  - Request to unsubscribe or change/update your email address can be completed by emailing edi.support@chpw.org
- ☐ For questions regarding the EFT form, please contact EDI Support at edi.support@chpw.org or call (206) 613-8810.

You are responsible for notifying CHPW of any changes to your banking information.

COMMUNITY HEALTH PLAN of Washington™

Electronic Funds Transfer (EFT) Form

Asterisk (*) indicates required fields

PROVIDER INFORMATION

Business Entity/Provider Name*

Street Address*

City* State* Zip Code*

Billing Address*

City* State* Zip Code*

PROVIDER IDENTIFIER INFORMATION

Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)*	Billing National Provider Identification Number (NPI)*
-	

If you DO NOT want all claims processed under this TIN set up for EFT, please choose from one of the following options:

☐ NPI Level Setup - EFTs will only be transmitted for the billing NPIs that are enrolled. Be sure to list the two or more NPIs you would like to enroll

☐ Split by Billing Address - Enroll only certain Billing Locations under the Tax ID for EFT payments.

List applicable Billing Locations to enroll for EFT payments

PROVIDER CONTACT INFORMATION

Primary Contact Name* Title

Telephone number* ( ) - ext.

Email Address* Fax Number ( ) -

FINANCIAL INSTITUTION INFORMATION

Name on Account*

Bank Name* Address*

City* State* Zip Code*

Type of Account* ☐ Checking ☐ Savings

Financial Institution Routing Number*

Account Number*

**For official use only – box to be completed by CHPW

Vendor ID:

COMMUNITY HEALTH PLAN of Washington™

SUBMISSION INFORMATION

Reason for Submission* ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

Requested EFT start/change/cancel effective date

EFT Email Notification – Please provide an email address where CHPW can send notification when an EFT is transmitted to your financial institution:*

AUTHORIZATION AGREEMENT

I hereby authorize Community Health Plan of Washington (CHPW), on behalf of its affiliates, including Community Health Network of Washington, to initiate credit entries to the bank account listed on this form for all medical claims and capitated payments. This agreement will remain in effect until the provider notifies CHPW of the desire to change or cancel this service, or until CHPW provides notification that this service has been terminated. It is understood that reasonable time will be allowed to execute instructions.

The bank listed on this form is authorized to accept any credit entries made by CHPW to such account and to credit the same to such account. CHPW will not debit or deduct funds directly from the bank account listed for claim overpayments and/or refund request. CHPW will seek permission to debit the listed bank account for any adjustments or corrections to resolve duplicate payments (where "duplicate" is defined as CHPW sending multiple identical payments in error) or erroneous payment due to a bank account setup in error. CHPW will attempt to recover the duplicate or erroneous payment via a debit to the account to the extent permitted by state law and with prior contact to the provider. If an electronic debit is unsuccessful, CHPW will notify the provider in writing to reach an alternative arrangement for reimbursement.

*CHPW strictly adheres to the National Automated Clearing House Association (NACHA) guidelines.

By signing below, I hereby agree that I have read and agree to the terms and conditions stated on this form. Furthermore, the undersigned certifies that the information provided is true and accurate in all respects and that he/she has been duly authorized by all necessary and appropriate action.

Written Signature of Person Submitting Form*

Printed Name of Person Submitting Form*

Title of Person Submitting Form*

Submission Date*

Submit the completed form, along with a voided check and/or bank letter, to:

Email - DS.CHPW.prov.maint@nttdata.com

OR mail to - Community Health Plan of Washington
PO Box 269002
Plano, TX 75026-9002

COMMUNITY HEALTH PLAN of Washington™

Definitions - Electronic Funds Transfer (EFT) Form

PROVIDER INFORMATION	
Business Entity/Provider Name	Complete legal name of institution, corporate entity, practice, or individual provider
Street Address	The number and street name where a person or organization can be found
Billing address	Address (PO Box, Lockbox, etc.) associated with TIN number
PROVIDER IDENTIFIER INFORMATION	
Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	A Federal Tax identification Number, also known as an Employer Identification number, is used to identify a business entity.
Billing National Provider Identification Number (NPI)	A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they liver or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.
PROVIDER CONTACT INFORMATION	
Primary Contact Name	Name of a contact for business entity/provider authorized to handle EFT issues.
Email Address	An electronic mail address at which the health plan might contact the business entity/provider.
FINANCIAL INSTITUTION INFORMATION	
Name on Account	The business entity/provider name to which EFT payments will be paid to.
Bank Name	Official name of the financial institution where the business entity/provider maintains an account
Address	The street address associated with bank name
Type of Account	The type of account the business entity/provider uses to receive EFT payments.
Financial Institution Routing Number	A 9-digit identifier of the financial institution where the business entity/provider maintains an account.
Business entity/Provider Account Number	Business entity/provider account number at the financial institution to which EFT payments are to be deposited.
SUBMISSION INFORMATION	
What to include with Enrollment	Completed EFT form and a pre-printed voided check to provide confirmation of Identification/Account numbers, or a Bank letter on bank letterhead that formally certifies the account owners routing and account numbers.
Reason for Submission	Indicate the reason for submitting form from the options available.
Requested EFT start/change/cancel effective date	The date on which the requested action is to begin.
AUTHORIZAION AGREEMENT	
Authorized Signature	The signature of an individual authorized by the business entity/provider to initiate, modify, or terminate EFT enrollment.
Submission Date	The date on which the enrollment is signed by the authorized individual and submitted.