



Delaware Physicians Care, Incorporated  
252 Chapman Road • Suite 250 • Newark DE 19702 • 1-800-287-9860 • Fax: 866-886-2839

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## Electronic Funds Transfer (EFT) Authorization Enrollment

Please use the guide to prepare and complete your EFT enrollment request. Missing or incomplete information within the enrollment form will delay the benefits of participating in EFT. The following is a reference guide only. Do not fax with the completed enrollment form.

- Are you using one enrollment form per tax id?**
  - Enrollment forms containing more than one tax id will be returned.
  
- Did you remember to put the NPI # on the enrollment form?**
  - Having a valid NPI on file aids in the processing of your request.
  
- Have you attached a voided check or bank letter for new enrollments or changes in bank information?**
  - Enrollment requests cannot be processed without this information.
  - A voided check must accompany the form; a copy of the Deposit Slip will not be accepted.
  - The banking information on the voided check/bank letter must match what is listed on the form.
  
- Has the form been signed by the appropriate individuals?**
  - The form MUST be signed by two people: an *authorized health care professional* – MD, CFO, CEO, etc. **AND** a *supervisor-level authorized personnel* – office manager, billing manager, etc.
  - Your enrollment form will be returned if there is only one signature.
  
- Have you completed all sections marked with an asterisk?**
  - Incomplete and/or illegible fields will cause the form to be returned.
  - To ensure form is legible, please type or print all requested information clearly.
  
- Have a completed form to submit?**
  - Submit only one form per fax. Multiple enrollment requests must be faxed separately. Faxes containing multiple forms will be returned.
  - Completed forms should be faxed to **866-886-2839**.
  - Please allow 10-15 business days for processing once enrollment is received before requesting status. Backlog may occur which could result in a longer processing time.
  - A letter will be sent to the “Primary Billing Address” on the enrollment form once setup is complete.



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## Electronic Funds Transfer (EFT) Authorization Form

**\*Indicates required fields within each section. Incomplete and/or illegible fields or missing signatures may cause your enrollment to be delayed.**

**Provider/Practice Information:**

*Name	*Tax ID Number (TIN)	Pay to/Billing National Provider Identifier (NPI)
*Contact Name		*Email Address
*Telephone Number (      )		*Fax Number (      )
Primary Service Address		*Primary Billing Address

**Check Only One**

NEW EFT Authorization
  EFT Termination Request  
 Update/Change Information (i.e. changes to account # or bank)

**EFT – Direct Deposit/Banking Information:**

**When enrolling a new account or changed account for EFT, a voided check or letter from your bank is required. Your bank must be a participating member of the Automated Clearinghouse Association (ACH). You are responsible for notifying Delaware Physicians Care if your banking information changes. New EFT enrollment or changes to existing EFT banking information will trigger a new EFT pre-note period. The EFT pre-note period can run 10 to 15 days from the processing date of the approved EFT Authorization Form.**

\*Bank Name \_\_\_\_\_ Address \_\_\_\_\_

\*Bank Routing Number (9 digits found on check, NOT deposit slip) 

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Account Number \_\_\_\_\_ (voided check or bank letter required)

Account Type:     Checking     Savings

TIN Number of Provider associated with above account \_\_\_\_\_

**Please be aware, follow-up by a Delaware Physicians Care representative to a supervisor-level authorized personnel may occur to ensure accuracy of banking information.**

**Page 1 of 2 – Authorization Agreement on next page – must be completed and submitted with Page 1 for EFT Authorization Form to be accepted.**

**Authorization Agreement – Please read and sign your name below.**

**Electronic Funds Transfers (EFT)**

We, the Provider, certify that the bank account information listed on page 1 of this form is under our direct control. We authorize Delaware Physicians Care, Incorporated (DPCI), on behalf of itself and its affiliates to initiate credit entries to the account at the bank listed on page 1 for all benefits payments. We authorize and request the bank to accept credit entries by DPCI to such account and to credit the same to such account.

We, the Provider, understand that if our account is closed and a new EFT Authorization Form has not been submitted and processed, we will not receive payment until our bank returns the funds to DPCI. This authorization remains in effect until we submit an updated EFT Authorization Form requesting termination or change and until such time that DPCI has had a reasonable opportunity to act on such request or DPCI notifies us that this service has been terminated. If our depository information changes, we agree to submit an updated EFT Authorization Form to that effect.

If DPCI credits more money than the correct benefits amount to the account, due to duplicate electronic funds transfers (where “duplicate” is defined as multiple electronic funds transfers received for the same services rendered, the same membership and the same dates of service) or erroneous electronic funds transfers (where “erroneous” is defined as complete electronic funds transfers received in error), DPCI will attempt to recover the duplicate or erroneous payment via a debit to the account. If an electronic debit is unsuccessful, will pursue settlement via alternative measures.\*

\*DPCI 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 above. Note, two signatures are required: Authorized health care professional AND supervisor-level authorized personnel need to sign. Missing and/or illegible signatures will cause your enrollment to be delayed.**

**Authorized health care professional may be MD, CFO, CEO, etc.**

\*Authorized health care professional name: \_\_\_\_\_

\*Title \_\_\_\_\_

\*Signature \_\_\_\_\_ \*Date \_\_\_\_\_

**Supervisor-level authorized personnel may be Office Manager, Billing Manager, etc.**

\*Supervisor-level authorized personnel name: \_\_\_\_\_

\*Title \_\_\_\_\_

\*Signature \_\_\_\_\_ \*Date \_\_\_\_\_

\*Form completed by \_\_\_\_\_

\*Telephone Number (\_\_\_\_\_) \_\_\_\_\_ Fax Number (\_\_\_\_\_) \_\_\_\_\_

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

**Please FAX completed form, voided check and/or bank letter to: DPCI Provider Relations Representative at 866-886-2839. Please note this is a dedicated fax number specifically for EFT Enrollment only. Please submit only one form per FAX. Faxes containing multiple forms will be returned.**

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**DPCI Processing Verification Section:**

**Date Form Received from provider: \_\_\_\_\_ Bank Information Verified (Initial): \_\_\_\_\_**

**Date Entered into Provider Payment Set-up Web Application: \_\_\_\_\_**

**Provider ID Number(s) if not setting up all providers with the same TIN:**