DELAWARE PHYSICIANS CARE
AN AETNA MEDICAID PLAN℠

Electronic Funds Transfer (EFT) Authorization Form

☐ **New EFT Authorization** ☐ **EFT Termination Request**

☐ **Update/change Information (i.e., Changes to account or bank)**

Provider Information

Provider Group Name: _____
DBA, if applicable: _____
Tax Identification Number (EIN or TIN): ___ ___ ___ ___ ___ ___ ___ ___ ___
Contact Name: _____
Contact Phone Number: _____

Bank or Financial Institution Information

Bank / Financial Institution Name: _____
Address:_____
City: _____ State: _____ Zip Code: _____
ACH/EFT Contact Name: _____
ACH/EFT Contact Phone Number: (_____)-_____ - _____
Routing Transit Number: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____
Account Number: _____
Type of Account (Please Check one of the Following) ☐ Checking ☐ Savings

Authorization

We, the provider, certify the above checking or savings account is under out direct control. Therefore, we authorize Delaware Physicians Care, Inc. to initiate credit entries (and/or adjustments for any credit entries made in error) directly into the bank/ Finical institution account number listed above. We authorize the Bank / Finical institution to post the credit and/or debit to the same account.

We understand that if our account is closed, we will not receive payment until our bank returns the funds to Delaware Physicians Care, Inc. This authorization remains in effect until we submit an updated EFT Authorization Form requesting termination and until such time that Delaware Physicians Care, Inc. has had a reasonable opportunity to act on such request. If our depository information changes, we agree to submit an updated EFT Authorization Form.

Signature

Authorized Provider Representative: _____
(Print Name)
Authorized Provider Representative: _____
(Signature)
Job Title: _____ Date: _____

General Information

*** Attach a VOIDED check for verification of your account number.***

Completed forms and attachments should be returned by mail or faxed to the following:

Delaware Physicians Care, Inc.
Attn: Provider Relations
252 Chapman Road, Suite 250
Newark, DE 19702

Fax: 866-886-2839
OR

Internal Use Only

Date Form Received by Plan: _____ Bank Information Verified (initial): _____
Provider ID Number: _____ Date Provider Set-Up: _____