Authorization Agreement for Electronic Funds Transfer (EFT)

Established vendors can use this standalone EFT authorization to initialize, change, or cancel their EFT status. **Non-established vendors should not** complete this form but must instead submit the Vendor Setup Packet, which includes EFT authorization.

Save time, submit online!
Instead of completing this PDF, you can now submit this information online at alliancehealthplan.org/forms/5.

Request type

1

What is the nature of this request? *

◯ **Initialize** EFT (established vendors only) ◯ **Change** EFT information ◯ **Cancel** EFT authorization

Vendor information

If the vendor legal name you listed is an individual, generally your taxpayer identification number (TIN) is your social security number (SSN). For other entities, it is your employer identification number (EIN). Both the legal name and TIN should match Alliance Health records.

2

Vendor legal business name * _____
Must match name on financial institution account and name registered with Alliance Health

Address line 1 * _____ Address line 2 _____
Street, P.O. Box, etc. Suite, Building, etc.

City * _____ State * _____ Postal code * _____

Taxpayer identification number (TIN): *

Social security number (SSN) | **OR** | Employer identification number (EIN)

Email * _____ Phone * _____
For electronic remittance forms to be sent

Financial institution information

5

Account holder's name * _____

Routing number *

Account number *
Include leading zeros

Type of account * ◯ Checking ◯ Savings

Financial institution name* _____

Are you attaching a blank, voided check or a bank-generated account verification form? ◯ Yes ◯ No

If neither of these documents are provided as requested, Alliance Health does not accept responsibility for the accuracy of the above typed/written account information submitted.

We request that you include a blank, voided check or bank-generated account verification form for account and routing number verification.

Continue form on next page

Authorization

4

Please select to authorize or cancel this EFT below:*

- ○ This authorization is effective as of the signature date below and is to remain in full force and effect until Alliance Health has received written notification of its termination in such time and such manner as to afford Alliance Health and the financial institution a reasonable opportunity to act on it, or until Alliance Health deems it necessary to terminate this agreement. Under penalties of perjury, I hereby certify the checking OR savings account indicated on this form are under my direct control and access; therefore, I authorize Alliance Health to initiate, change, or cancel credit entries to the financial institution account as indicated above. If my financial institution information changes, I agree to submit to Alliance Health a revised Authorization Agreement for Electronic Funds Transfer form.
- ○ I hereby CANCEL my EFT authorization.

I understand that by signing this form, payments issued will be Federal and State funds, and that any falsification or concealment of a material fact may be prosecuted under Federal and State laws.

Print name * _____

Signature (sign or type) *		Date (mm/dd/yyyy) *
x		

Submission instructions

ONLINE: If you submitted this information online, no additional steps are required.
PAPER: If you did not submit the online form, please save and/or scan the completed form and email it to VendorSetup@AllianceHealthPlan.org.