PLAN DE SALUD MENONITA

EFT ENROLLMENT FORM FOR PROVIDER

PROVIDER INFORMATION

Provider Name	
Address	
City / State / Zip Code	
Contract Name	Email Address
Telephone	Fax Number
Tax ID Number	Provider NPI Number

FINANCIAL INSTITUTION INFORMATION

Nine Digits Routing Transit Number									
Account Number									
Account Name									
Type of Account	☐ Checking				☐ Savings				
Bank Name				Bank Branch					

I authorize Plan de Salud Menonita to make electronic credits to my accounts in the above specified financial institution.

SUBMISSION INFORMATION

Reason for Submission	☐ New	☐ Change
Authorized Signature	Date (MM/DD/YYYY)	

THIS SECTION COMPLETED BY PROVIDER

Authorized Signature	Date (MM/DD/YYYY)

Plan de Salud Menonita has the right to adjust future payments or debit to the provider's account via ACH if payments previously made are found to be duplicated, in excess of requirements, fraudulent of in error.

Return this completed form to Plan de Salud Menonita via email to: provider_vital_ach@planmenonita.com
Please include a voided check or deposit slip