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# ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

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## PART I: REASON FOR SUBMISSION

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### Reason for Submission:

- New EFT Authorization                      Effective Date \_\_\_\_\_
- Revision to Current Authorization              Effective Date \_\_\_\_\_  
(e.g. account or bank changes)
- Cancel EFT    Effective Date \_\_\_\_\_

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## PART II: PROVIDER OR SUPPLIER INFORMATION

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Provider/Supplier Legal Business Name

Chain Organization Name or Home Office Legal Business Name (if different from Chain Organization Name)

Account Holder's Street Address

Account Holder's State

Account Holder's Zip Code

Tax identification Number: (designate  SSN or  EIN)

Medicare Identification Number (if issued)

National Provider Identifier (NPI)

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## PART III: FINANCIAL INSTITUTION INFORMATION

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Financial Institution Name

Financial Telephone Number

Financial Institution Contact Person

Financial Institution Routing Transit Number (nine digit)

Depositor Account Number

Type of Account (check one)

Checking Account       Savings Account

Please include a confirmation of account information on bank letterhead or a voided check. When submitting the documentation, it should contain the name on the account, electronic routing transit number, account number and type. If submitting bank letterhead, the bank officer's name and signature is also required. This information will be used to verify your account number.

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## PART IV: CONTACT PERSON

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Contact Person's Name

Contact Person's Title

Contact Person's Telephone Number

Contact Person's E-mail Address

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**PART V: AUTHORIZATION**

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*The undersigned hereby authorizes Sharp HealthCare to initiate deposits, credits and/or corrections to previous credits to the financial institution indicated above. The financial institution is authorized to credit and /or correct the amounts to the account shown. This authority is to remain in full force and effect until the undersigned revokes it, by giving 10 days written notice to Sharp HealthCare, or if stopped due to the undersigned's termination as a contracted provider.*

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**SIGNATURE LINE**

Authorized/Delegated Official Name (Print)

Authorized/Delegated Official Telephone Number

Authorized/Delegated Official Title

Authorized/Delegated Official E-mail Address

Authorized/Delegated Official Signature (Note: Must be original signature in black or blue ink.)

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