Electronic Funds Transfer Enrollment for Medical Capitation ONLY - not to be used to enroll in EFT for Medical Claims

Please fax only one TIN per form. A separate form for each TIN must be used.

	Sections required to be completed	Enroll	Change	Terminate
EFT for Medical Capitation	**ALL**	☐	☐	☐

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

A. Practice Information – *Please note: Illegible or incomplete fields may cause your enrollment to be delayed.*

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

B. EFT - Direct Deposit/Banking Information

When enrolling a *new* or *changed* account for EFT, a voided check or letter from your bank is required.

To take advantage of direct deposit (EFT), your bank must be a participating member of the Automated Clearinghouse Association (ACH). Please note if you require payments to be deposited into multiple bank accounts, you must complete bank account information for each account. Capitation payments made under a single TIN can only be deposited into one bank account. New EFT enrollment or changes to existing EFT banking information will trigger a new EFT pre-note period. The EFT pre-note period will run for 10 days from the effective date. Production will start on day 11. You are responsible for notifying Aetna if your banking information changes.

* **Bank Name** ______________________________ **Address** ____________________________________

* **Bank routing number** (9 digits found on check, NOT deposit slip) ☐☐☐☐☐☐☐☐☐

* **Account Number** _________________________________ **(voided check or bank letter required)**

* **Account type** ☐ Savings ☐ Checking ☐ Deposit Only

* **TIN number of provider associated with above account** _______________________________________

If information supplied above is a change request, please provide the following information:

* **Previous Bank Name** ______________________ **Previous Address** ____________________________

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

* **Previous Account Number** _______________________

* **Account type** ☐ Savings ☐ Checking

* **TIN number of provider associated with above account** _______________________________________

When enrolling a *new* or *changed* account for EFT, a voided check or letter from your bank is required.

Please be aware, follow-up by an Aetna representative to a supervisor-level authorized health care professional may occur to ensure accuracy of banking information.

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

Electronic Funds Transfers (EFT)

I hereby authorize Aetna, on behalf of itself and its affiliates, including Aetna Life Insurance Company and Aetna Health Inc. (hereinafter "Company"), to initiate credit entries to the account(s) at the bank(s) listed above for all benefits payments. This agreement will remain in effect until I notify Company of the desire to cancel or change this service or until Company notifies me that this service has been terminated. I understand I must allow reasonable time for my instructions to be executed. I authorize and request the bank(s) listed above to accept any credit entries by Aetna to such account(s) and to credit the same to such account(s).

If Company 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 membership) or erroneous electronic funds transfers (where "erroneous" is defined as complete electronic funds transfers received in error), company will attempt to recover the duplicate or erroneous payment via a debit to your account. If an electronic debit is unsuccessful, or for deposit only accounts, company will pursue settlement via alternate measures.*

* Company 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, including Authorization for Direct Deposit of Benefits Payments, Legislative Updates and Pended Claims.

* Authorized health care professional name: ________________________________ * Title ____________

Signature ____ * Date ____________

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

* Supervisor - level authorized personnel:

____ * Title ____________

Signature ____ * Date ____________

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

* Form completed by ____

* Telephone number (_____)______________________ Fax number (_____)______________________

* Email address: ____

*** One authorized health care professional AND one supervisor-level authorized personnel signature is required.**

*** Incomplete and/or illegible signatures will cause your enrollment to be delayed**

Please submit only one form per FAX. Faxes containing multiple forms will be returned.

Fax the completed form, voided check and/or bank letter to Aetna Capitation Administration at 860-262-9596.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies. (Aetna)