IMPERIAL HEALTH PLAN
OF CALIFORNIA

Claim Payment

Electronic Funds Transfer (EFT) Authorization Agreement

◯ New ◯ Change ◯ Cancel

Provider Name		**Tax ID** □ **EIN** □ **SSN**	
Street	**City**	**State**	**Zip**
Provider Contact	Phone	**Fax**	** **Email**
** The EOB for payment will be sent ONLY via email once you enroll to receive claim payment via EFT. If EOB should be sent to a different email, please list a different email here: _____			
Financial Institution		**Phone**	
Account Name	** **ABA/Routing No.**		
Account Type: □ Checking □ Saving	** **Account No.**		
** Please include a confirmation of account information on bank letterhead or a voided check for account verification. If submitting bank letterhead, the bank officer's name and signature is required.			

Attach Voided Check Here

VOIDED CHECK COPY

I hereby authorize Imperial Health Plan of California, Inc. (IHPC) to initiate credit entries to the account at the financial institution indicated above. This agreement will remain in effect until I notify IHPC of any changes or corrections to my bank account information or until IHPC notifies me that this service has been terminated. I understand that it will take approximately four weeks to process my enrollment, change or cancellation request from the date received by IHPC. I understand that IHPC reserves the right to reverse direct deposit of funds paid in error.

_____ _____

Approved Provider Signature (Account Holder) Date

_____ _____

Printed Name Request Start Date (Month/Year)

Please send your completed form along with the voided check or bank letter to IHPC by email at

PDM@imperialhealthholdings.com.

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