curative

NOTE: **Complete all sections below and attach a voided check or a signed letter from your bank on bank letterhead along with a current W9.**

Type of authorization: ☐ **New** ☐ **Change**	**Line of Business** *(check all that apply)*: PPO ☐ Curative Health Plan ☐
Provider name:	**Billing TPI or Tax ID/EIN:** *(9-digit)*
National Provider Identifier (NPI)/Atypical Provider Identifier (API):	**Primary taxonomy code:**
Provider accounting address: **Number Street Suite City State ZIP**	
Provider phone number:	
Provider Request Electronic Funds Transfer (EFT) ☐ Yes ☐ No	
Bank name:	**Bank phone number:**
ABA/Transit number:	**Account number:**
Bank address:	**Account type:** *(check one)*
	☐ Checking ☐ Savings

I (we) hereby authorize Curative Health Plan to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I (we) am responsible for the validity of the information on this form. If the company erroneously deposits funds into my (our) account, I (we) authorize the company to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay period.

I (we) will continue to maintain the confidentiality of records and other information relating to clients in accordance with applicable state and federal laws, rules, and regulations.

Authorized signature:	**Date:**
Title:	**E-mail address:** *(if applicable)*
Contact name:	**Contact phone number:**

Please return this form to:

Curative Health Plan
PO BOX 15594
Austin, TX 78761