



### EFT Enrollment Form

I've attached the following required documents: <input type="checkbox"/> W-9 <input type="checkbox"/> Bank Letterhead or Voided Check	
Type of authorization: <i>(Check one)</i> <input type="checkbox"/> New <input type="checkbox"/> Change	Account type: <i>(Check one)</i> <input type="checkbox"/> Checking <input type="checkbox"/> Savings
Provider name:	Billing TPI or Tax ID/EIN: (9-digit)
National Provider Identifier (NPI)/Atypical Provider Identifier (API):	Group NPI (if applicable):
Provider accounting address:	Provider phone number:
Bank ABA/Transit number:	Bank account number:
Bank Name:	Which clearinghouse do you use?

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 <i>(if applicable)</i> :
Contact name:	Contact phone number <i>(optional)</i> :

**To Return This Form:****By Mail:**

Curative Health Plan  
 PO BOX 1786  
 Austin, TX 78767

**By Fax:** [866-813-7747](tel:866-813-7747)

**By email:** [providerrelations@curative.com](mailto:providerrelations@curative.com)

**Need Help?**

**Call Provider Support:** [855-414-1083](tel:855-414-1083)