

Instructions to Complete the: Rider 2 – Electronic Funds Transfer

Page 1(Complete Provider Information)

Page 1, Paragraph 1

The day, month, and year the Funds Transfer Rider is completed.
Indicate both Provider's name and agreement number (Tax ID).

Page 7, "Signature Page"

(Complete the provider's information using the left-hand column)

Agreed to:

Type or print provider's name
("The Trading Partner")

By: Provider's Signature (be sure to sign on the left-hand side of page 7)
(Authorized signature)

If the provider does not sign the Rider-2 Funds Transfer, the individual signing on behalf of the provider **must** be authorized to bind the provider to a legal contract. Stamp signatures are not acceptable.

Name: Type or print the name of the authorized individual.

Title: Type or print the title of the authorized individual.

Address: Type or print the address of the provider.

City, State, Zip: Type or print the city, state, and zip code of the provider.

Date: Date Funds Transfer Rider is authorized.

Contact Person: Type or print the name of the person who can be contacted by Health Care Service Corporation for additional administrative information.

Title: Type or print the contact person's title.

Telephone: Type or print the area code and phone number of the contact person.

Fax: Type or print the fax number of the contact person.

E-Mail: Type or print the E-mail address of the contact person.

Revised Information Date: Use only for subsequent changes to Rider 2-Funds Transfer. Type or print the date of all revised information and send a copy of changes to:

**Health Care Service Corporation
Electronic Commerce Services Unit- 25th Floor
300 East Randolph Street
Chicago, IL 60601**

Please be sure to keep a copy of the signed agreement for your records.

Page 8
Blue Shield EFT Information

1.1 Bank Designations

The Trading Partner's Bank: Please check the appropriate box to indicate if this is *new* or *revised* funds transfer information.

Provider Name: Type or print the name of the provider.

Provider No: Indicate provider Blue Shield number.

Provider Tax No.: Indicate provider's tax identification number.

Bank Name: Type or print the name of the bank where the provider's funds will be deposited.

Address: Type or print the address of the bank where the provider's funds will be deposited.

City, State, Zip: Type or print the city, state, and zip code of the bank where the provider's funds will be deposited.

Telephone: Type or print the telephone number of bank where the provider's funds will be deposited.

Type of Account: Indicate whether the bank account is "Demand Deposit" or "Savings".

Account No: Type or print the number of the bank account where the provider's funds will be deposited.

American Bankers Association (ABA) No: Indicate the 9-digit transit number of the provider's bank. This can be found on either the provider's deposit slip or check. *Please attach deposit ticket or cancelled check.*

Lockbox No. If applicable, please indicate the provider's Lockbox Number.

Branch Name: Indicate the Branch name of the provider's bank.

Administrative Contact: Type or print the name of the person who can be contacted by Health Care Service Corporation for additional information.

Completed By: Type or print the name of the person who completed the Rider 2 – Electronic Funds Transfer.

Completed Date: Indicate the date the Rider 2 – Electronic Funds Transfer Rider is completed.

Remittance Information: Please check box to indicate if you are requesting electronic remittance information **with funds** transfer or if you are requesting funds transfer **without** the electronic remittance information.

Page 9
Blue Cross EFT Information

1.1 Bank Designations

The Trading Partner's Bank: Please check the appropriate box to indicate if this is a *new* or *revised* funds transfer information.

Provider Name: Type or print the name of the provider.

Provider No: Indicate Blue Cross provider number.

Provider Tax No.: Indicate provider's tax identification number.

Bank Name: Type or print the name of the bank where the provider's funds will be deposited.

Address: Type or print the address of the bank where the provider's funds will be deposited.

City, State, Zip: Type or print the city, state, and zip code of the bank where provider's funds will be deposited.

Telephone: Type or print the telephone number of bank where the provider's funds will be deposited.

Type of Account: Indicate whether the bank account is "Demand Deposit" or "Savings".

Account No: Type or print the number of the bank account where the provider's funds will be deposited.

American Bankers Association (ABA) No: Indicate the 9-digit transit number of the provider's bank. This can be found on either the provider's deposit slip or check. *Please attach deposit slip or cancelled check.*

Lockbox No. If applicable, please indicate the provider's Lockbox Number.

Branch Name: Indicate the Branch name of the provider's bank.

Administrative Contact: Type or print the name of the person who can be contacted by Health Care Service Corporation for additional information.

Completed By: Type or print the name of the person who completed the Rider 2 – Electronic Funds Transfer.

Date Completed : Indicate the date the Rider 2 – Electronic Funds Transfer Rider is completed.

Remittance Information: Please check box to indicate if you are requesting electronic remittance information **with funds** transfer or if you are requesting funds transfer **without** the electronic remittance information.

Individual completing the Rider 2-Funds Transfer should initial the lower right-hand corner of each page where "TP" is indicated.

*Blue Cross Blue Shield of Illinois
An Independent Licensee of the
Blue Cross Blue Shield Association*