

Instructions to Complete the: HCSC Electronic Funds Transfer Agreement

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BLUE CROSS BLUE SHIELD EFT INFORMATION

New EFT Enrollment or Revised Enrollment: Indicate if the EFT Agreement is New or Revised.

Please Check Appropriate Payment Cycle and State that is being enrolled.

The Trading Partner's Information:

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

National Provider Identifier (NPI): Indicate the National Provider Identifier.

Blue Cross Blue Shield Provider No: Indicate the provider's Blue Cross Blue Shield number, if NPI is not applicable, for example "Atypical Provider".

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

The Trading Partner's Bank Information:

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

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

Bank Routing Number/American Bankers Association (ABA) Number: Indicate the 9-digit transit number of the provider's bank. This can be found on either the provider's deposit slip or check. *It is imperative that you attach to the HCSC Electronic Funds Transfer Agreement, an original voided check or a statement/ letter from your bank with the requested information.*

Bank Account Number: Type or print the number of the bank account where the provider's funds will be deposited.

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

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

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

Completed By: Type or print the name of the person who completed the HCSC Electronic Funds Transfer Agreement.

Completed Date: Indicate the date the HCSC Electronic Funds Transfer Agreement was completed.

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BLUE CROSS BLUE SHIELD EFT INFORMATION (CON'T)

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)
(Authorized signature)

*If the provider does not sign the HCSC Electronic Funds Transfer Agreement, 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 signing this Agreement.

Title: Type or print the title of the authorized individual signing this Agreement.

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 HCSC Electronic Funds Transfer Agreement is authorized.

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

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

Telephone Number: Type or print the area code and telephone 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 the HCSC Electronic Funds Transfer Agreement. Type or print the date of all revised information and send a copy of changes to:

Health Care Services Corporation
Electronic Commerce Services – 25th Floor
300 East Randolph Street
Chicago, IL 60601