Form #6

OPTUM Care®
Network of Connecticut

Electronic Funds Transfer (EFT) Enrollment Form

Return completed forms to:
Email: edioperations@nammcal.com
Fax: 860-409-4077
Mail:
OptumCare Network of Connecticut
3 Farm Glen Blvd.
Farmington, CT 06032

Please PRINT clearly. Please allow 7 to 10 working days for Electronic Funds Transfer (EFT) enrollment processing.

Provider Information (REQUIRED)

Provider Name:		
Provider Address Street:		
City:	State/Province:	ZIP Code/Postal Code:

Provider Identifiers (REQUIRED)

Provider Federal Tax Identification Number (TIN) or Employer Identification Number:	
National Provider Identifier (NPI):	

Provider Contact Information

Provider Contact Name:		Title:
Telephone Number:	Telephone Number Extension:	Email Address:

Financial Institution Information (REQUIRED)

Financial Institution Name:	
Financial Institution Routing Number:	Type of Account at Financial Institution: **(SELECT ONE)** ☐ **CHECKING** ☐ **SAVINGS**
Provider's Account Number with Financial Institution:	

Account Number Linkage to Provider Identifier: (SELECT ONE)

☐ Provider Tax Identification Number (TIN) ☐ National Provider Identifier (NPI)

Submission Information

Reason for Submission: ☐ NEW Enrollment ☐ CHANGE Enrollment ☐ CANCEL Enrollment

Include with Enrollment Submission (at least one) ☐ Voided Check ☐ Bank Letter

The undersigned hereby certifies that the information provided herein is true and accurate in all respects and that he/she has been duly authorized by all necessary and appropriate corporation action, where applicable, to execute this agreement on behalf of the above mentioned Provider Name to form a legally binding contract. The undersigned authorizes OptumCare Network of Connecticut, and their affiliates (collectively referred to as "OCNCT") to deposit payments for claims paid by OCNCT into the accounts listed above. In addition, the undersigned hereby agrees that OCNCT may initiate credit entries and/or initiate error adjustments for duplicate or erroneous entries made to the account listed above.

This Authorization is to remain in full force and effect until OCNCT has received written notification from the undersigned of its termination in such time and manner as to afford OCNCT a reasonable opportunity to act on it.

Authorized Signature:_____ Date:_____

Printed Name of Person Submitting Enrollment

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