ANTIDOTE

PO Box 39638, Solon, OH 44139

Electronic Funds Transfer (EFT) Request

Please read and agree to the following items. Complete the requested information and send securely to AHEFT@shninc.org or mail to Antidote Health Plan, PO Box 369368, Solon, OH 44139.

1. Provider hereby agrees to Electronic Funds Transfer (EFT) for Antidote Health claims payments.

2. Provider agrees to inform Antidote Health of any updates to these documents at least 20 days before making changes. Until the changes are implemented, we will send a check to the payment address we have on file.

3. EFT shall be subject to all rules, procedures, and requirements of the banking institution involved and of any concerned regulatory agencies.

4. Provider hereby represents and warrants that this request for payment via EFT is signed by an executive or officer-level authorized representative and they hereby represent and warrant that they are authorized to make this request on behalf of the Provider. The Provider will also assign an individual to act as a contact for the account.

5. By completing this form, you are hereby authorizing enrollment into the Antidote Health EFT program; including validation of data provided through a third-party Antidote Health partner. Please allow seven (7) days for account verification.

PROVIDER (COMPANY) NAME:	PROVIDER (COMPANY) TAX ID/SS #:

Authorized Officer

This is a person in an executive or officer-level position.

NAME:	SIGNATURE:	
TITLE:	DATE:	PHONE:

Account Representative

This is the point of contact for Antidote Health Accounts Payable in the event any questions may arise regarding the provided account information.

NAME:	SIGNATURE:	
TITLE:	DATE:	PHONE:
EMAIL ADDRESS:		FAX:

Note: Electronic Funds Transfer (EFT) Authorization must accompany this request. Incomplete forms will be returned.

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For company and individual use:

BANK NAME:			
ROUTING NUMBER:	ACCOUNT NUMBER:		
TAX ID:	NAME ON BANK ACCOUNT:		
ADDRESS:	CITY:	STATE:	ZIP CODE:

Last payment to you from Antidote Health (if applicable):

DATE:	AMOUNT:

Contact information:

PHONE NUMBER:	FAX NUMBER:	EMAIL ADDRESS:

For individual use only:

SSN:	FIRST NAME:	LAST NAME:

Remit address if different from above:

ADDRESS:	CITY:	STATE:	ZIP CODE:

Please note:

- Only checking accounts can be accepted for ACH Electronic Funds Transfer (EFT).
- Allow seven (7) business days for account verification and enrollment completion.
- An authorized bank account holder must sign this form.

I hereby authorize Antidote Health or its affiliates to initiate deposit (credit) payments to the financial institution indicated above. Antidote Health will comply with all ACH rules as stated in the National Automated Clearing House Association ACH Rules in conjunction with the administration of any payments to this account. This authority is to remain in full force and effect until I revoke it by giving 20 days prior written notice to Antidote Health.

Account Representative:

NAME:	SIGNATURE:	
TITLE:	DATE:	PHONE:
EMAIL ADDRESS:		FAX:
REQUESTED START DATE (REQUIRED FOR EXISTING PROVIDERS):		