Health Net of California

Health Net

Health Net of California Electronic Funds Transfer (EFT) Authorization Agreement

Provider Information

Provider Name ____

Provider Address Street ____

City ________________________ State ______ Zip _________________

Provider Identifiers Information

Provider Identifiers

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) _____________________

National Provider Identifier (NPI) _____________________

Provider Contact Information

Provider Contact Name ____ Title ____________________________

Telephone Number ______________________ Fax Number ________________________

Email Address ____

Financial Institution Information

Financial Institution Name ___________________________________

Financial Institution Routing Number ____________________________

Type of Account at Financial Institution O Checking O Savings

Provider's Account Number with Financial Institution_______________________________________

Account Number Linkage to Provider Identifier**

O Provider Tax Identification Number (EIN) _________________

O National Provider Identification Number (NPI) _________________

Submission Information

Reason for Submission O New Enrollment O Change Enrollment O Cancel Enrollment

Include with Enrollment Submission O Voided Check O Bank Letter

Authorized Signature

Written Signature of Person Submitting Enrollment _____________________________________

Printed Title of Person Submitting Enrollment ____

Submission Date _________________ Requested EFT Start/Change/Cancel Date ________________

Provider expressly authorizes Health Net to credit entries (or, if necessary, debit entries and adjustments for any credit entries made in error) to the above-referenced Bank Account number. Provider accepts responsibility for any resulting loss of payment and releases Health Net of any liability for or arising from Provider's failure to submit accurate or updated information to Health Net relating to the Bank Account. This authorization is to remain in effect until written notice in the form of an EFT cancellation or change form is submitted to Health Net. The termination or change shall be effective 10 days subsequent to Health Net's receipt of the updated form.

**Must match ERA grouping

Fax Completed Form to 1-800-677-4147

Instructions for completing the EFT Registration form:

Please type or print legibly.
Use only black or blue ink to complete form.
Please allow 4 weeks for registration process which includes pre-note verification. If after 4 weeks you do not start receiving EFT then you may contact the EDI Team at 1-800-977-3568 or you can go to www.Healthnet.com/provider for other contact information.

For questions about this form, please call the EDI Unit at 1-800-977-3568.

Provider Information

Provider Name – Please fill out completely.
Provider Address – Complete legal name of institution, corporate entity, practice or individual provider.
Street – The number and street name where a person or organization can be found.
City - City associated with provider address field.
State – Character code associated with the State. 2 digits.
Zip Code – Postal zone code.

Provider Identifiers

Provider Federal Tax Identification Number (TIN) – A federal tax identification number or Employer identification number used to identify a business 9 digits.
National Provider Identifier (NPI) – HIPAA unique provider identifier 10 digits.

Provider Contact Information

Provider Contact Information: Enter the name, title, phone number and e-mail address of the person authorized to provide the EDI staff with information that relates to EFT payments or inquiries.

Financial Institution Information

To avoid processing delays, include a copy of a voided check or authorized bank letter providing verification of bank account number and bank routing transit number.

Financial Institution Name - Enter the designated Financial Institution name.
Financial Institution Routing Number - Enter the Bank routing transit number.
Type of Account at Financial Institution: - Indicate whether the account your EFT payments will be deposited to is a checking or savings account. Check only one box.
Provider Account Number with Financial Institution - Enter the bank account number (not to exceed 17 digits).
Account Number Linkage to Provider Identifier: Provider preference for grouping (bulking) claim payments – must match preference for v5010 X12 835 remittance advice. Please select only one option.
Providers Tax Identification Number (TIN) – A federal tax identification number (TIN) or Employer identification number (EIN) Numeric, 9 digits.
National Provider Identifier (NPI) – Unique identification number for covered healthcare providers. Numeric, 10 digits

Reason for Submission: Must select one from below

New Enrollment – Enrollment of new EFT account.
Change Enrollment - This information facilitates the registration transition from the old to the new bank account and expedites processing your bank account change.
Cancel Enrollment – Use to terminate receipt of EFT payments.
Include with Submission: Please include a copy of a voided check if checking account is being used or authorized bank letter providing verification of bank account number and bank routing transit number.
Written Signature of Person Submitting Enrollment - Signature of preparer or responsible individual.
Printed Name of Person Submitting Enrollment – Printed Signature of preparer or responsible individual.
Printed Title of Person Submitting Enrollment - Enter the title of the person who signs the form.
Submission Date - Enter the date submitted for enrollment.
Requested EFT Start/Change/Cancel Date – Date for the requested action to become effective.

Health Net

Fax the completed form to: 1-800-677-4147

The provider must contact its financial institution to arrange for the delivery of the CORE required Minimum CCD+ data elements needed for reassociation of the payment and the ERA. See Phase III
CORE EFT & ERA Reassociation (CCD+/835) Rule Version 3.0.0.