Electronic Fund Transfer Automatic Deposit Authorization Agreement

I authorize SummaCare Inc, to initiate credit entries into the account(s) indicated below and authorize the financial institution/bank named below; to credit the same to such account(s).

If the account is drawn in the Physician's or Individual Practitioner's Name, or the Legal Business Name of the Provider/Supplier, the Physician/Provider/Supplier certifies that he/she has sole control of the account(s) below, and certifies that all arrangements between SummaCare Inc and the said Physician/Provider/Supplier are in accordance with all applicable Medicare regulations and instructions.

This authorization agreement is effective as of the signature date below and is to remain in full force and effect until SummaCare Inc has received written notice of termination at least 30 days prior to the termination date. If my banking account information changes, I agree to submit the corrections to SummaCare Inc in an updated EFT Authorization Agreement.

NOTE: SummaCare Inc makes claim payments based on the National Provider Identifier assigned to the provider. When a provider is paid to a group or practice, all other providers under that same group or practice will also be paid by Electronic Fund Transfer.
To view or print copies of your Remits, please logon or register at Plan Central: http://www.summacare.com/Provider/ResourcesAndSelfServices.aspx

Is this an update to the information that we already have on file? ☐ Yes

Providers Information

Providers Name: ______________________

Providers Tax Identification Number: ______________________

National Provider Identifier (NPI): ______________________

Providers Address: ______________________

Providers City, State, Zip Code: ______________________

Providers Phone Number: ______________________

Providers Email Address: ______________________

Contact Name: ______________________

Banking Information:

Bank Name: ____________________

Bank Routing Number: ____________________

Bank Account Number: ____________________

Bank Address: ____________________

Bank City, State, Zip Code: ____________________

Bank Phone Number: ____________________

What type of Account is this? ☐ Checking ☐ Savings

Name of person authorizing the Electronic Fund Transfer:

Please Print: ____________________ Date: ____________________

Signature of person authorizing the Electronic Fund Transfer:

Sign: ____________________ Date: ____________________

Please mail this completed form with either a voided check or Bank Letter to:
SummaCare
Attn: EDISUPPORT
P.O. Box 3620
Akron, OH 44309-3620

If you have any questions, please contact Provider Support Services at 330.996.8400, toll free 1.800.996.8401 or you can send an email to contactproviderservices@summacare.com