Print Form

UHA HEALTH INSURANCE
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EFT REQUEST FORM

For UHA Use Only
Provider Reference _____

The information provided on this form will be used to set up your office for Electronic Funds Transfer (EFT). **Please complete this form as accurately as possible**. If a section is not applicable, write "N/A."

Mail, Fax or Email your completed form to: **UHA**
Attention: Contracting Services
700 Bishop Street, Suite 300
Honolulu, HI 96813
Email: ContractingServices@uhahealth.com | Fax: 1-866-572-4383

I. Provider Information

Provider Name: _____
(Complete legal name of institution, corporate entity, practice or individual provider)

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

II. Provider Identifiers Information

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

_____

III. Provider Contact Information

Provider Contact Name: _____
Telephone Number: _____
Email Address: _____
Fax Number: _____

IV. Financial Institution Information

Financial Institution Name: _____
Financial Institution Routing Number: _____
Type of Account at Financial Institution: **Checking Accounts Only**
Provider's Account Number at Financial Institution: _____
Account Number Linkage to Provider Identifier:
Provider Tax Identification Number (TIN): _____
Reason for Submission: ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment
Include with Enrollment Submission: ☐ Voided Check ☐ Bank Letter
Authorized Signature:
Written Signature of Person Submitting Enrollment _____
Printed Name of Person Submitting Enrollment: _____
Printed Title of Person Submitting Enrollment: _____