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EFT REQUEST FORM

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: _____