

# Instructions to Complete the: HCSC Electronic Funds Transfer Agreement

## Page 1(Complete Provider Information)

### Page 1, Paragraph 1

The day, month, and year the Funds Transfer Agreement is completed.  
Indicate both Provider's name and agreement number (Tax ID).

### Page 8 "Signature Page"

*(Complete the provider's information using the left-hand column)*

**Agreed to:**

Type or print provider's name  
("The Trading Partner")

**By:** Provider's Signature (be sure to sign on the left-hand side of page 8)  
(Authorized signature)

If the provider does not sign the HCSC Electronic Funds Transfer Agreement, the individual signing on behalf of the provider **must** be authorized to bind the provider to a legal contract. Stamp signatures are not acceptable.

**Name:** Type or print the name of the authorized individual.

**Title:** Type or print the title of the authorized individual.

**Address:** Type or print the address of the provider.

**City, State, Zip:** Type or print the city, state, and zip code of the provider.

**Date:** Date HCSC Electronic Funds Transfer Agreement is authorized.

**Contact Person:** Type or print the name of the person who can be contacted by Health Care Service Corporation for additional administrative information.

**Title:** Type or print the contact person's title.

**Telephone:** Type or print the area code and phone number of the contact person.

**Fax:** Type or print the fax number of the contact person.

**E-Mail:** Type or print the E-mail address of the contact person.

**Revised Information Date:** Use only for subsequent changes to the HCSC Electronic Funds Transfer Agreement. Type or print the date of all revised information and send a copy of changes to:

**Health Care Service Corporation  
Electronic Commerce Services Unit – 25<sup>th</sup> Floor  
300 East Randolph Street  
Chicago, IL 60601**

*Please be sure to keep a copy of the signed agreement for your records.*

**Page 11**  
**Blue Cross Blue Shield EFT Information**

**1.1 Bank Designations**

**The Trading Partner's Bank:** Please check the appropriate box to indicate if this is *new* or *revised* funds transfer information.

**Please Check Appropriate Payment Cycle:** Daily, Weekly, - Bi-weekly (New Mexico Only)

**Provider Name:** Type or print the name of the provider.

**Provider No:** Indicate provider Blue Shield number.

**National Provider Identifier (NPI):** Indicate your National Provider Identifier.

**Provider Tax No.:** Indicate provider's tax identification number.

**Bank Name:** Type or print the name of the bank where the provider's funds will be deposited.

**Address:** Type or print the address of the bank where the provider's funds will be deposited.

**City, State, Zip:** Type or print the city, state, and zip code of the bank where the provider's funds will be deposited.

**Telephone:** Type or print the telephone number of bank where the provider's funds will be deposited.

**Type of Account:** Indicate whether the bank account is "Demand Deposit" or "Savings".

**Account No:** Type or print the number of the bank account where the provider's funds will be deposited.

**American Bankers Association (ABA) No:** Indicate the 9-digit transit number of the provider's bank. This can be found on the provider's check. *It is imperative that you attach to the HCSC Electronic Funds Transfer Agreement, a voided check or a statement/ letter from your bank with the requested information.*

**Lockbox No.** If applicable, please indicate the provider's Lockbox Number.

**Branch Name:** Indicate the branch name of the provider's bank.

**Administrative Contact:** Type or print the name of the person who can be contacted by Health Care Service Corporation for additional information.

**Completed By:** Type or print the name of the person who completed the HCSC Electronic Funds Transfer Agreement.

**Completed Date:** Indicate the date the HCSC Electronic Funds Transfer Agreement was completed.

*Health Care Service Corporation,  
A Mutual Legal Reserve Company,  
An Independent Licensee of the  
Blue Cross Blue Shield Association*

*EFT-INS 05/07*