

# Instructions to Complete the: HCSC Electronic Funds Transfer Agreement

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## BLUE CROSS BLUE SHIELD EFT INFORMATION

**New EFT Enrollment or Revised Enrollment:** Indicate if the EFT Agreement is New or Revised.

**Please Check Appropriate Payment Cycle and State that is being enrolled.**

### The Trading Partner's Information:

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

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

**Blue Cross Blue Shield Provider No:** Indicate the provider's Blue Cross Blue Shield number, if NPI is not applicable, for example "Atypical Provider".

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

### The Trading Partner's Bank Information:

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

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

**Bank Routing Number/American Bankers Association (ABA) Number:** Indicate the 9-digit transit number of the provider's bank. This can be found on either the provider's deposit slip or check. *It is imperative that you attach to the HCSC Electronic Funds Transfer Agreement, an original voided check or a statement/ letter from your bank with the requested information.*

**Bank Account Number:** Type or print the number of the bank account where the provider's funds will be deposited.

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

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

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

**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.

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## BLUE CROSS BLUE SHIELD EFT INFORMATION (CON'T)

**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)  
(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 signing this Agreement.

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

**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 (HCSC) for additional administrative information.

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

**Telephone Number:** Type or print the area code and telephone 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 – 25<sup>th</sup> Floor  
300 East Randolph Street  
Chicago, IL 60601