

**UNISON HEALTH PLANS  
AUTHORIZATION TO INITIATE ELECTRONIC FUNDS TRANSFER (EFT)**

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I am a participating Unison Health Plan Provider and hereby elect to receive electronic funds transfer (EFT) for all payments made by or on behalf of Unison Health Plans (Unison).

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**Provider Information\***

Provider Name: \_\_\_\_\_

Unison Provider ID #: \_\_\_\_\_ (attach listing if applying for multiple providers)  
(Leave blank if new provider)

National Provider Identifier (NPI #): \_\_\_\_\_ (attach listing if applying for multiple providers)

Provider Address: \_\_\_\_\_  
\_\_\_\_\_

Tax ID Number: \_\_\_\_\_

*\*Note that Electronic Funds Transfer will occur at the payee level only. For multiple individual providers linked to a single Payee – the EFT will be set up for the payee and will include all providers under that payee.*

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**Banking Information**

\_\_\_\_\_  
(Name on account)

\_\_\_\_\_  
(Tax Id number)

\_\_\_\_\_  
(Address on account)

\_\_\_\_\_  
(Banking Institution name and address)

\_\_\_\_\_  
(Account Number)

\_\_\_\_\_  
(Routing Number)

Type of Account:     Checking                      or                       Savings

**\*\*Please attach a Voided Check to this document.**

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**835 – Electronic Remittance Advice (ERA) Authorization**

To be eligible for EFT, you must also elect to accept 835 electronic remittance advices. If you are not already receiving the 835 electronic remittance advice or in testing with Unison, completion of this form will initiate testing.

Note that the 835 format does not provide Unison the ability to communicate billing alert information that was previously sent with the paper remittance and check. Upon conversion to EFT, you can receive future billing alerts via fax. Please provide us with a fax number that should be used to send your organization information regarding billing instructions, claims processing requirements and/or changes.

**FAX NUMBER** \_\_\_\_\_

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**Authorized Individual**

I hereby authorize Unison to initiate 835 and EFT to the above-indicated account and to the financial institution indicated in this form to credit monies to the same such account. I further authorize Unison to initiate EFTs to debit such account as necessary to correct any previous credit made in error. Unison will notify the Provider prior to such a debit. I also authorize UHP to contact me or the individuals designated below in connection with the administration of the EFT.

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**This authorization shall remain in full force and effect until terminated by the above named Provider(s) upon thirty (30) days written notice to Unison Health Plan.**

PLEASE RETURN FORM TO:     **Unison – Provider Administration**  
  **Unison Plaza**  
  **1001 Brinton Road**  
  **Pittsburgh, PA 15221**

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**Alternate Authorized Individuals for EFT if different than the individual completing this form:**

**Authorized to make changes to Banking Information/Tax ID or to terminate Electronic Funds Transfer:**

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Other contact:**

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Contact for: \_\_\_\_\_