ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

PART I: REASON FOR SUBMISSION

Reason for Submission:

☐New EFT Enrollment
☐Individual ☐Group

☐Change to Current EFT Enrollment
(e.g. account or bank changes)

☐Revalidation

☐Check here if EFT payment is being made to the Home Office of the Chain Organization
(Attach letter authorizing EFT payment to Chain Home Office)

PART II: ACCOUNT HOLDER INFORMATION

Provider/Supplier Legal Business Name (if individual, please provide first name, middle initial, last name, and suffix)

Chain Organization Name or Home Office Legal Business Name (if different from Chain Organization Name)

Account Holder's City | Account Holder's State | Account Holder's Zip Code

Payee Tax Identification Number (TIN)

Designate TIN
☐SSN (enrolling as an individual) OR
☐EIN (enrolling as a group/organization/corporation

Payee Practice National Provider Identifier Number (NPI)

Medicare Identification Number (if issued)

PART III: FINANCIAL INSTITUTION INFORMATION

Financial Institution's Name

Financial Institution Routing Number (must be 9 digits)

Type of Account (check one)
☐Checking Account
☐Savings Account

Provider's/Supplier's Account Number with Financial Institution (include all zeros)

PART IV: CONTACT PERSON

This it the person we will contact for any questions regarding this EFT.

Contact Person's Name | Contact Person's Title

Contact Person's Telephone Number | Contact Person's E-mail Address

PART IV: AUTHORIZATION

I hereby authorize MCA-Sedgwick to provide the financial institution and account data to the World Trade Center Health Program for validation and release of payment.

This authorization agreement is effective as of the signature date below and is to remain in full force and effect until MCA-Sedgwick has received written notification from me of its termination in such time and such manner as to afford MCA-Sedgwick a reasonable opportunity to act on it. The World Trade Center Health Program payment vendor will continue to send the direct deposit to the Financial Institution indicated above until notified by me that I wish to change the Financial Institution receiving the direct deposit. If my Financial Institution information changes, I agree to submit to MCA-Sedgwick an updated EFT Authorization Agreement.

SIGNATURE LINE

Authorized/Delegated Official Name (Print)	Authorized/Delegated Official Telephone Number
Authorized/Delegated Official Title	Authorized/Delegated Official E-mail Address
Authorized/Delegated Official Signature (Note: Must be signed and dated to process)	Date

Please fax the completed form to MCA-Sedgwick at 866.728-7860 or email a copy to

WTCNPN-ProviderServices@sedgwickgovernment.com.