

EFT (Electronic Fund Transfer) Pre-Authorization Claims Disbursement Form



You must be registered with a clearinghouse to enroll in EFT (Electronic Fund Transfer). For more information visit <https://www.aspirushealthplan.com/Business/ProviderResources> and select Provider EDI Resources.

After your 835 registration has been established, please have your clearinghouse send confirmation of your registration to our administrator, PreferredOne: 835@preferredone.com.

Return completed, signed form via Email to: Credentialing@Preferredone.com or Fax to: 763.847.4814.

PROVIDER INFORMATION			
Provider Name		Tax ID Number	
Mailing Address	City	State	Zip Code
Type of Account (<i>check one</i>) <input type="checkbox"/> Checking <input type="checkbox"/> Savings Required: Include a voided check with this request. A letter from your financial institution with your business name, bank routing number and account number will also be accepted. We are unable to process your request without proper documentation.			
Special Instructions: (<i>include specific NPIs or types of services if applicable</i>)			

AUTHORIZATION

The Provider hereby requests that claims reimbursement be made electronically into the financial institution named on attached voided check or financial institution letter. Electronic signatures must be certified.

I represent that I am the account holder and certify under penalty of perjury that I have completely read and fully understand the terms and conditions of this form and that all the representations made by me on this form are true, correct and complete. I understand that there may be consequences for providing false information or omission of relevant information. I understand that I may be subject to penalties under law if I provide false or untrue information.

Provider Contact Name	Provider Contact Email	Provider Contact Phone
Authorized Provider Signature		Date