AUTHORIZATION AGREEMENT FOR ELECTRONIC TRANSFER OF FUNDS

I Hereby authorize and request Mountain Health, as claims administrator to initiate credit entries as designated owing to me for services rendered to the account indicated below in the depository financial institution named below, hereafter called DEPOSITORY. This request becomes EFFECTIVE WITHIN TWO WEEKS OF RECEIPT OF THIS DOCUMENT. Thereafter, credits for services rendered will be direct deposit. It is very important that you verify account and ABA numbers with your Depository Institution. Incorrect format can lead to rejection or delay of the funds.

☐ New Authorization ☐ Termination ☐ Replace Current

☐ Savings or ☐ Checking _____ Depository Institution _____ ABA/Transit Number* _____ Account Number

Bank Contact Information _____ Name _____ Telephone Number

Provider Email _____

This authority is to remain in full force and effect until WHPS has received written notification from me on its termination in such time and in such manner as to afford WHPS a reasonable time to act on it.

TAX IDENTIFICATION NUMBER _____ DATE: _____

PROVIDER NAME _____ SIGNATURE _____

(Please Print)

NOTE: Please attach either a voided blank check for Checking or savings account deposit slip for Savings account changes or complete banking information on the bank's letterhead is required to complete the request.
Email completed documents to: WHPS.ASOMHCproviderservices.ext@wipro.com

* Bank's routing number taken from the MICR line of the recipient's check.
The first digit should be 0, 1, 2, or 3. A routing number starting with 4-9 is usually not valid.

Revised 08/15/24