

# Authorization for Automatic Deposits

Please PRINT:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Company Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State Zip+4

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Provider NPI #

\_\_\_\_\_  
Tax ID #

This authority is for all contracted providers currently associated with this Tax ID number, as well as any contracted providers added to this Tax ID number in the future.

I (we) authorize Blue Cross Blue Shield of Arizona (BCBSAZ), an independent licensee of the Blue Cross Blue Shield Association, to initiate credit entries to my (our) checking or savings account indicated below. In the event erroneous credits are posted to my (our) account. I authorize BCBSAZ or my (our) financial institution to initiate the necessary adjustment entries. I further agree if BCBSAZ or my (our) financial institution is unable to initiate the necessary adjustment entries, I (we) will return the erroneous monies to BCBSAZ upon demand. Furthermore, I authorize the financial institution listed below to accept such entries to the named account.

\_\_\_\_\_  
Financial Institution Name

\_\_\_\_\_  
Branch

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State Zip+4

\_\_\_\_\_  
Account Number

Checking     Savings

This authority is to remain in full force and effect until BCBSAZ receives written notification from me (us) of its termination in such time and manner as to afford BCBSAZ and the financial institution a reasonable opportunity to act on it.

\_\_\_\_\_  
Signature of Authorized Signer      Date

\_\_\_\_\_  
Signature of Authorized Signer      Date

Activation may take up to 30 days.

Return this authorization form to:

Provider Network Management S101  
Blue Cross Blue Shield of Arizona  
PO Box 13466  
Phoenix, AZ 85002-3466  
(602) 864-4231  
Fax: (602) 864-3142

**Please staple voided check here.**

If you have a deposit only account, please provide a letter from your financial institution with ACH routing information and bank account information.

Please check one of the following:

- New EFT  
or
- Change to existing EFT  
or
- Cancel my existing EFT  
Effective date of cancellation \_\_\_\_\_



An Independent Licensee of the Blue Cross and Blue Shield Association