



# Enrollment of EFT and ACH funding For Senior CommUnity Care PACE Insurance Payments

## ***Provider/ Account Details***

Provider/Organization Name: \_\_\_\_\_

Tax Identification Number (TIN): \_\_\_\_\_

National Provider Identification (NPI) \*if applicable: \_\_\_\_\_

Billing Contact Name: \_\_\_\_\_

Billing Contact Phone Number: \_\_\_\_\_

Billing Contact Email Address: \_\_\_\_\_

## ***Banking Information***

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

Bank routing Number (9 Digits): \_\_\_\_\_

Bank Account Number: \_\_\_\_\_

Account Type (Checking or Savings): \_\_\_\_\_

Name on Bank Account: \_\_\_\_\_

Bank Address (City, State, Zip): \_\_\_\_\_

**\*Please attach a Voided Check or Bank Letter to confirm your banking details.**

## ***Remittance Delivery Preferences***

Preferred Method to Receive Remittance advice (RA): ☐ Provider Portal ☐ Clearinghouse

Clearinghouse Information (if applicable): \_\_\_\_\_

## **Acknowledgement and Authorization**

By signing below, I acknowledge that:

- I am authorized to enroll this provider in EFT.
- The information provided above is accurate.
- I understand EFT will replace mailed checks for all future payments.
- I will notify SCC PACE immediately of any changes to the banking or remittance information provided.
- EFT enrollment may take up to 30 days.

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

Authorized Representative Name (Printed): \_\_\_\_\_

Title/Position: \_\_\_\_\_

**\*\*Submit your completed form to VOANS SCC PACE via fax to: (612) 409-7311\*\***