



# Electronic Funds Transfer (EFT) Authorization Form

Provider Name: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Provider City, State, Zip:  
\_\_\_\_\_

Provider Federal Tax Identification Number (or SSN): \_\_\_\_\_

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

Bank Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Routing Number: \_\_\_\_\_ Account Number: \_\_\_\_\_  
(9 digits)

Checking Account

Savings Account

By signing below, I hereby authorize My Choice Wisconsin to deposit claim payments to my account indicated above at the depository financial institution named above. I acknowledge that the origination of Automated Clearing House (ACH) transactions must comply with the provisions of U.S. law. Claim payments will be made after the claim has been adjudicated by our claims processor. I further acknowledge that I will no longer receive paper remittance advices, but must retrieve them electronically for payment reconciliation. This authorization is to remain in full force and effect until My Choice Wisconsin has received written notification from me of its termination in such time and in such manner as to afford My Choice Wisconsin and the financial institution indicated above, a reasonable opportunity to act on it. I certify that the information provided is true and accurate in all respects and that I have been duly authorized to perform transactions on this account.

Authorized by: \_\_\_\_\_ Phone: \_\_\_\_\_  
(Print Name and Title)

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

**~REMEMBER TO ATTACH A VOIDED CHECK FOR CHECKING ACCOUNTS  
OR A DEPOSIT SLIP FOR SAVINGS ACCOUNTS ~**

**FAX to: 608-245-3340**

**or scan and E-mail to: [Provider-Help-Desk@carewisc.org](mailto:Provider-Help-Desk@carewisc.org)**

My Choice Wisconsin Use Only:

Reviewed and approved by: \_\_\_\_\_ Date: \_\_\_\_\_

Confirmed With: \_\_\_\_\_ Date: \_\_\_\_\_

# Electronic Funds Transfer (EFT) Fact Sheet

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Automatic payment is a voluntary service that My Choice Wisconsin offers to help with your claim payments. To sign up for the service, complete this form and return it with a voided check for checking accounts, or a deposit slip for savings accounts. Please allow 30 days processing time for EFT to begin. If you have multiple Tax ID Numbers (TINs), you must submit one form per TIN.

**Features:**

- We will automatically deposit your claim payments to your bank account.
- Your provider remittance advice will only be available electronically via the HIPAA 835 transaction when you submit your claims using the HIPAA 837 transactions.
- When you submit a claim on paper, via spreadsheet, or electronically using the Claims Web Portal, your provider remittance advice will only be available on the Claims Web Portal.
- You can start or end the service at any time.

**Benefits:**

- Quick, Easy, Convenient.
- Free service.
- Ability to access your remittance advice electronically.