



Electronic Funds Transfer Enrollment

Please use this guide to prepare and complete your EFT enrollment request. Missing or incomplete information within the enrolment form will delay the benefits of participating in EFT. The following is a reference guide only, do not fax with the completed enrollment form.

- Are you using one enrollment form per tax id?**
 - Enrollment forms containing more than one tax id will be returned.

- Did you remember to put the NPI # on the enrollment form?**
 - Having a valid NPI on file aids in the processing of your claims.

- Have you attached a voided check or bank letter?**
 - Enrollment requests cannot be processed without this information.
 - A voided check must accompany the form; a copy of the Deposit Slip will not be accepted.
 - The banking information on the voided check/bank letter must match what is listed on the enrollment form.

- Has the form been signed by the appropriate individuals?**
 - The form **MUST** be signed by two people: an *authorized healthcare professional* – MD, CFO, CEO, etc. **AND** a *supervisor-level authorized personnel* – office manager, billing manager, etc.
 - Your enrollment form will be returned if there is only one signature.

- Have you filled out all of the sections marked with asterisks?**
 - Incomplete and/or illegible fields will cause the form to be returned.
 - To ensure form is legible, please type or print all requested information clearly.

- Have a completed form to submit?**
 - Submit only one form per fax. Multiple enrollment requests must be faxed separately. Faxes containing multiple forms will be returned.
 - Completed forms should be faxed to 860-907-4731.
 - Please allow 10-15 business days for processing once an enrollment is received before requesting status. Backlog may occur which could result in a longer processing time.
 - An email confirmation will be sent once setup is complete.



Electronic Funds Transfer Enrollment

For EFT new enrollment only: Form is effective 3/1/10 to 12/31/10. For changes to existing EFT/ERA set-up please refer to the EFT/ERA enrollment form at: <http://www.aetna.com/healthcare-professionals/claims-administration/billing-payment-reimbursement.html>

** Indicates required fields within each section. Incomplete and/or illegible fields and signatures may cause your enrollment to be delayed.*

Practice Information – Please note: Illegible or incomplete fields may cause your enrollment to be delayed.

* Name	* Tax ID Number (TIN)	* Pay to/Billing National Provider Identifier (NPI)
* Contact Name	* Email Address	
* Telephone Number ()	Fax Number ()	
Primary Service Address	Primary Billing Address	

Check Only One

- TIN level set up (select when all claims are paid to the same tax ID)
- EFT's split by billing location
- EFT's split by NPI - Provide 2 or more NPI's.

Note: When split by NPI, EFT will be generated for only those NPIs provided.

EFT- Direct Deposit/Banking Information

When enrolling a *new* account for EFT, a voided check or letter from your bank is required.

To take advantage of direct deposit (EFT), your bank must be a participating member of the Automated Clearinghouse Association (ACH). Please note if you require payments to be deposited into multiple bank accounts, you must complete bank account information for each account. Capitation payments made under a single TIN can only be deposited into one bank account. New EFT enrollment or changes to existing EFT banking information will trigger a new EFT pre-note period. The EFT pre-note period will run for 10 days from the effective date. Production will start on day 11. You are responsible for notifying Aetna if your banking information changes.

* **Bank Name** _____ * **Address** _____

* **Bank Routing Number** (9 digits found on check, NOT deposit slip)

--	--	--	--	--	--	--	--	--

* **Account Number** _____ (voided check or bank letter required)

* **Account type:** Savings Checking Deposit Only

* **TIN number of provider associated with above account** _____

When enrolling a *new* account for EFT, a voided check or letter from your bank is required.

Please be aware, follow-up by an Aetna representative to a supervisor-level authorized health care professional may occur to ensure accuracy of banking information.

Authorization Agreement – Please read and sign your name below.

Electronic Funds Transfers (EFT)

I hereby authorize Aetna, on behalf of itself and its affiliates, including Aetna Life Insurance Company and Aetna Health Inc. (hereinafter “Company”), to initiate credit entries to the account(s) at the bank(s) listed above for all benefits payments. This agreement will remain in effect until I notify Company of the desire to cancel or change this service or until Company notifies me that this service has been terminated. I understand I must allow reasonable time for my instructions to be executed. I authorize and request the bank(s) listed above to accept any credit entries by Aetna to such account(s) and to credit the same to such account(s).

If Company credits more money than the correct benefits amount to the account, due to duplicate electronic funds transfers (where “duplicate” is defined as multiple electronic funds transfers received for the same services rendered, the same membership and the same dates of service) or erroneous electronic funds transfers (where “erroneous” is defined as complete electronic funds transfers received in error), company will attempt to recover the duplicate or erroneous payment via a debit to your account. If an electronic debit is unsuccessful, or for deposit only accounts, company will pursue settlement via alternate measures.*

* Company strictly adheres to the National Automated Clearing House Association (NACHA) guidelines.

By signing below, I hereby agree that I have read and agree to the terms and conditions stated above.

* Authorized health care professional name: _____

* Title _____

* Signature _____ * Date _____

Authorized health care professional may be MD, CFO, CEO, etc.

* Supervisor-level authorized health care professional name: _____

* Title _____

* Signature _____ * Date _____

Supervisor-level authorized health care professional may be Office Manager, Billing Manager, etc.

* Form completed by _____

* Telephone Number (____) _____ Fax Number (____) _____

* Email Address: _____

*** One authorized health care professional AND one supervisor-level authorized health care professional signature is required.**

*** Incomplete and/or illegible signatures will cause your enrollment to be delayed.**

**Please FAX completed form, voided check and/or bank letter to Aetna EFT Enrollment at 860-907-4731.
Please note this is a dedicated fax number specifically for EFT Enrollment.**