Managed Health Network

Managed Health Network (MHN) Electronic Funds Transfer (EFT) Authorization Agreement

Provider Information

Provider Name _____

Provider Address Street _____

City _____ State _____ Zip _____

Provider Identifiers Information

Provider Identifiers

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) _____

National Provider Identifier (NPI) _____

Provider Contact Information

Provider Contact Name _____ Title _____

Telephone Number _____ Fax Number _____

Email Address _____

Financial Institution Information

Financial Institution Name _____

Financial Institution Routing Number _____

Type of Account at Financial Institution O Checking O Savings

Provider's Account Number with Financial Institution_____

Account Number Linkage to Provider Identifier O Provider Tax Identification Number (EIN)
O National Provider Identification Number (NPI)

Submission Information

Reason for Submission O New Enrollment O Change Enrollment O Cancel Enrollment

Include with Enrollment Submission O Voided Check O Bank Letter

Authorized Signature

Electronic Signature of Person Submitting Enrollment _____

Printed Title of Person Submitting Enrollment _____

Submission Date _____ Requested EFT Start/Change/Cancel Date _____

Provider expressly authorizes Managed Health Network (MHN) to credit entries (or, if necessary, debit entries and adjustments for any credit entries made in error) to the above-referenced Bank Account number. Provider accepts responsibility for any resulting loss of payment and releases Managed Health Network (MHN) of any liability for or arising from Provider's failure to submit accurate or updated information to Managed Health Network (MHN) relating to the Bank Account. This authorization is to remain in effect until written notice in the form of an EFT cancellation or change form is submitted to Managed Health Network (MHN). The termination or change shall be effective 10 days subsequent to Managed Health Network's receipt of the updated form.

Fax Completed Form to 18558710938

Managed Health Network

Instructions for completing the EFT Registration form:
Please type or print legibly.
Use only black or blue font color (if typing) or black or blue ink (if printing) to complete form.
Please allow 4 weeks for registration process which includes pre-note verification. If after 4 weeks you do not start receiving EFT then you may contact the EDI Team at 1-800-977-3568 or you can go to https://www.mhn.com/provider/start.do for other contact information.

For questions about this form, please call the EDI Unit at 1-800-977-3568.

Section I: Provider Information

Provider Name – Please fill out completely.
Provider Address – Complete legal name of institution, corporate entity, practice or individual provider.
Street – The number and street name where a person or organization can be found.
City - City associated with provider address field.
State – Character code associated with the State. 2 digits.
Zip Code – Postal zone code.

Section II: Provider Identifiers

Provider Federal Tax Identification Number (TIN) – A federal tax identification number or Employer identification number used to identify a business 9 digits.
National Provider Identifier (NPI) – HIPAA unique provider identifier 10 digits.

Section III: Provider Contact Information

Provider Contact Information: Enter the name, title, phone number and e-mail address of the person authorized to provide the EDI staff with information that relates to EFT payments or inquiries.

Section IV: Financial Institution Information

Financial Institution Name - Enter the designated Financial Institution name.
Financial Institution Routing Number - Enter the Bank routing transit number.
Type of Account at Financial Institution: - Indicate whether the account your EFT payments will be deposited to is a checking or savings account. Check only one box.
Provider Account Number with Financial Institution - Enter the bank account number (not to exceed 17 digits).
Account Number Linkage to Provider Identifier: Must fill out one of the two options below.
Providers Tax Identification Number (TIN) – A federal tax identification number (TIN) or Employer identification number (EIN) Numeric, 9 digits.
National Provider Identifier (NPI) – Unique identification number for covered healthcare providers. Numeric, 10 digits

Section V: Reason for Submission: Must select one from below

New Enrollment – Enrollment of new EFT account.
Change Enrollment - This information facilitates the registration transition from the old to the new bank account and expedites processing your bank account change.
Cancel Enrollment – Use to terminate receipt of EFT payments.
Include with Submission: Please include a copy of a voided check if checking account is being used.
Written Signature of Person Submitting Enrollment - Signature of preparer or responsible individual.
Printed Name of Person Submitting Enrollment – Printed Signature of preparer or responsible individual.
Printed Title of Person Submitting Enrollment - Enter the title of the person who signs the form.
Submission Date - Enter the date submitted for enrollment.
Requested EFT Start/Change/Cancel Date – Date for the requested action to become effective.

Fax the completed form to: 1-855-871-0938

The provider must contact its financial institution to arrange for the delivery of the CORE required Minimum CCD+ data elements needed for reassociation of the payment and the ERA. See Phase III
CORE EFT & ERA Reassociation (CCD+/835) Rule Version 3.0.0.

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