Electronic Funds Transfer (EFT) Authorization Agreement

Provider Name	Doing Business As (DBA)
Provider Street Address	**Provider City**
Provider State/Province	**Provider ZIP Code/Postal Code**
Provider Tax Identifier (TIN) or Employer Identifier (EIN)	**National Provider Identifier (NPI)**
Assigning Authority	**Trading Partner ID**
Medicaid	
Provider Contact Name	**Provider E-Mail Address**
Provider Phone Number	**Provider Fax Number**
Financial Institution Name	**Financial Institution Street Address**
Financial Institution Telephone Number	**Financial Institution City/State/Zip**
Financial Institution Routing Number	**Type of Account at Financial Institution**
Provider's Account Number at Financial Institution	**Provider Preference for Grouping Claim Payments**
PLEASE ATTACH A VOIDED CHECK	**____ TIN or ____ NPI (Please √ one)**
Reason for Submission	
___ NEW ___ CHANGE ___ CANCEL (Please √ one)	

I (we) hereby authorize Sendero Health Plans to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I am (we are) responsible for the validity of the information on this form. If Sendero Health Plans erroneously deposits funds into my (our) account, I (we) authorize Sendero Health Plans to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay cycle.

I (we) agree to comply with all certification and credentialing requirements of Sendero Health Plans and the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by Sendero Health Plans or its authorized affiliate(s) or subcontractor(s). I (we) understand that payment of claims will be made from federal and state funds, and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

I (we) will continue to maintain the confidentiality of records and other information relating to clients covered by programs offered through Sendero Health Plans in accordance with applicable state and federal laws, rules, and regulations.

_____ _____

Authorizing Signature Date Signed

_____ _____

Printed Name Title of Signatory

For the convenience of having direct deposit, you must be willing to download your EOB/EOP directly from the https://sendero.valencehealth.com/Login.aspx?ReturnUrl=%2fDefault.aspx website. *No paper copies will be mailed.

RETURN THIS FORM ELECTRONICALLY TO providers@senderohealth.com OR:

Sendero Health Plans
ATTN: Network Management Department
2028 East Ben White Blvd, Ste 400
Austin, TX 78741

*Forms must be mailed-in or scanned and sent by e-mail. Fax copies WILL NOT be accepted due to readability.