CrestPoint Health
P.O. Box 3620
Akron, OH 44309-3620

Electronic Fund Transfer
Automatic Deposit
Authorization Agreement

I authorize CrestPoint Health, to initiate credit entries into the account(s) indicated below and authorize the financial institution/bank named below; to credit the same to such account(s).

If the account is drawn in the Physician's or Individual Practitioner's Name, or the Legal Business Name of the Provider/Supplier, the Physician/Provider/Supplier certifies that he/she has sole control of the account(s) below, and certifies that all arrangements between CrestPoint Health and the said Physician/Provider/Supplier are in accordance with all applicable Medicare regulations and instructions.

This authorization agreement is effective as of the signature date below and is to remain in full force and effect until CrestPoint Health has received written notice of termination at least 30 days prior to the termination date. If my banking account information changes, I agree to submit the corrections to CrestPoint Health in an updated EFT Authorization Agreement.

NOTE: CrestPoint Health makes claim payments based on the National Provider Identifier assigned to the provider. When a provider is paid to a group or practice, all other providers under that same group or practice will also be paid by Electronic Fund Transfer.

Go Paperless: To discontinue your paper explanation of payment (EOP), check the box below and your EOP/835 will be sent electronically.

Please discontinue my paper EOP and send an 835 (electronic EOP) in its place. YES ☐ NO ☐

Providers Information

Provider Name: _____

Provider Tax Identification Number: _____

National Provider Identifier (NPI): _____

Providers Address: _____

Providers City, State and Zip Code: _____

Providers Phone Number: _____

Providers Email Address: _____

Contact Name: _____

Banking Information

ACCOUNT #1

Bank Name: _____

Bank Routing Number: _____

Bank Account Name: _____

Bank Account Number: _____

Bank Address: _____

Bank City, State and Zip Code: _____

Bank Phone Number: _____

Is this account a Checking or Savings Account? _____

Name of person authorizing the Electronic Fund Transfer:

Please Print: _____

Signature of person authorizing the Electronic Fund Transfer:

Sign: _____ Date: _____

Please return this completed form with a copy of a cancelled check to:

CrestPoint Health
Attn: EDISUPPORT
P.O. Box 3620
Akron, OH 44309-3620

If you have any questions please call Provider Support Services at (423) 952-2190, toll free (888) 261-0417 or send email to providerservices.crestpoint@myplancentral.com.