

Direct Deposit Electronic Funds Transfer (EFT) Form

This form **MUST** be completed in **FULL** with the attachments indicated below or your request can not be completed.

1. Priority Health will transfer funds to checking or savings accounts.
 - Include an original **VOIDED** check with this request (*must be for the account designated below or alternatively, a letter from your financial institution stating your account information*).
2. Complete one (1) Agreement Form for each vendor number that is being requested.
 - Include a copy of page one of a current remittance advice with this request.
3. As necessary, please write-in additional Provider web account usernames that will receive notification.

Mail this **completed** form to:

Priority Health Payment, 1231 East Beltline NE, Grand Rapids MI 49525-4501

Practice/facility name: _____

Vendor number: _____

Vendor tax ID: _____ (must be same as W-9 currently on-file with Priority Health)

Provider bank information

Name: _____

Address: _____

City, State, ZIP: _____

Administrative contact: _____

Telephone (area+ number): _____

Account number (include leading zeros): _____

Account type (circle one): CHECKING or SAVINGS

American Bankers Association (ABA) number (9-digits): _____

Contact Information

Provider primary contact: _____

Provider primary contact e-mail address: _____

Provider primary *provider center* username (**required**): _____

Provider primary contact telephone number (area+ number) _____

Provider secondary contact: _____

Provider secondary contact e-mail address: _____

Provider secondary *provider center* username (**required**): _____

Provider secondary contact telephone number (area+ number) _____

Provider authorized signature: _____