Together with CCHP
PO Box 1997 - MS 6280 | Milwaukee, WI 53201-1997
Toll-free: 1-844-201-4672 | togetherCCHP.org

Electronic Funds Transfer (EFT) Authorization Form

Authorization for Electronic Reimbursement by Together with CCHP for medical services, if you are interested in receiving electronic payments, please complete the form below and fax to 1-844-549-3744 or mail to:
Together with CCHP
PO Box 106014
Pittsburgh, PA
15230-6014

Section 1: Provider Information

Name of Organization:		Federal Tax ID Number (TIN):	
Street Address:	City:	State:	Zip:

Section 2: Provider Contact Information (Name of person in provider's office who handles EFT)

Contact Name (First, Middle, Initial, Last):	Contact Title:	
Email:	Phone:	Fax:

Section 3: Financial Institution Information

Name of Depository:		Street Address:	
Account Name:	City:	State:	Zip:
Account Number:		Bank Routing Number:	
Type of Account (Check one): Checking ☐ Savings ☐			
PLEASE INCLUDE A COPY OF A VOIDED CHECK			

Section 4: Authorization Signature

Our Company:

1. Authorizes Children's Community Health Plan to make payments for services by EFT
2. Certifies that it has selected the listed depository institution; and
3. Directs that all such Electronic Funds Transfers be made as provided above

Internal Reference: TOG Provider – Provider Day Treatment Form (2017.0901)

4. Acknowledges and agrees that terms and conditions of all agreements with Children's Community Health Plan concerning the method and timing of payment for services shall be amended
5. Will give 30 days advance notice in writing to Children's Community Health Plan of any changes in its depository institution or other payment instructions.

When properly executed, this Authorization will become effective 15 days after its receipt by Children's Community Health Plan.

Authorized Signature: _____
Title _____
Name Printed: _____
Date Signed (MM/DD/YYYY): _____
Phone Number: _____