Direct Deposit/EFT Authorization Form
Fulcrum Health, Inc.

PROVIDER INFORMATION	
Provider Name (Legal name of business)	Doing Business As Name (DBA) – *if applicable*
Provider Address *(Street, City, State, ZIP Code)*	
PROVIDER IDENTIFIERS INFORMATION	
Provider Tax Identification Number (TIN - 9 digits)	National Provider Identifier (NPI – 10 digits)
PROVIDER CONTACT INFORMATION (Name of contact in provider office for handling the EFT process)	
Provider Contact Name	Provider Contact Telephone Number
Provider Contact Email Address (Email Address at which the health plan might contact the provider ***and*** that will receive notice of Direct Deposits):	
FINANCIAL INSTITUTION INFORMATION	
Financial Institution Name	
Financial Institution Routing Number (9 digits)	Type of Account at Financial Institution *(Check one)* ☐ Checking Account ☐ Savings Account
Provider's Account Number with Financial Institution	
SUBMISSION INFORMATION (check one)	
☐ New Enrollment	☐ Change Enrollment
AUTHORIZATION	
I hereby authorize Fulcrum Health, Inc. (Fulcrum) on behalf of itself, to initiate credit entries to the account at the bank listed above for all benefits payments. This agreement will remain in effect until I notify Fulcrum of the desire to cancel or change this service or until Fulcrum notifies me that this service has been terminated. I understand I must allow reasonable time for my instructions to be executed. I authorize and request the bank listed above to accept any credit entries by Fulcrum to such account and to credit the same to such account. If an electronic debit is unsuccessful for deposit accounts only or not permitted by state law, Fulcrum will pursue settlement via alternate measures.	
Authorized Signature	Printed Name
Submission Date	Requested EFT Start/Change/Cancel Date

BRIEF INSTRUCTIONS

A. **Complete the entire form and obtain an authorized signature. Detailed instructions are included on the following page.**
B. **Copy of a voided check or bank letter verifying your account information.**
C. **Mail or fax form and voided check or bank letter copy to:**

Fulcrum Health, Inc.
3300 Fernbrook Lane, Suite 150
Plymouth, MN 55447
Fax: 763-204-8544

D. **Allow 10-14 business days for your EFT enrollment to fully process. To check on the status of your enrollment after 14 business days, email your inquiry to accounting@fulcrumhealthinc.org .**

Direct Deposit/EFT Authorization Form
Fulcrum Health, Inc.

FORM INSTRUCTIONS AND GUIDANCE

Use this form to enroll in or change your Direct Deposit/EFT account with Fulcrum. Please type or print clearly and complete the entire form. ***If you want to receive the trace number associated with EFT transactions. Please contact your financial institution to ensure your account is properly set up.*** You can access Remittance Advice (RA) statements for your Electronic Funds Transfer (EFT) payments through CHIROCARE CONNECT. **PLEASE RECORD THE FOLLOWING INFORMATION, ALL FIELDS ARE REQUIRED**.

1. **PROVIDER INFORMATION**
    a. **PROVIDER NAME:** The complete, legal name of the business associated with the tax identification number (TIN). Only one authorization form is needed for each TIN.
    b. **DOING BUSINESS AS NAME (DBA):** If the business operates under a different name than the **PROVIDER NAME**.
    c. **PROVIDER ADDRESS:** The legal mailing address of the business.

2. **PROVIDER IDENTIFIERS INFORMATION**
    a. Provider Tax Identification Number (TIN – 9 digits)
    b. National Provider Identifier (NPI – 10 digits)

3. **PROVIDER CONTACT INFORMATION**
    a. Provider Contact Name: The name of the person to contact with questions or concerns at the provider's office.
    b. Provider Contact Telephone Number
    c. Provider Contact Email Address: Will receive the weekly email notifications of all direct deposits/EFT payments made for the associated Remittance Advice (RA) statements.

4. **FINANCIAL INSTITUTION INFORMATION**
    a. Financial Institution Name
    b. Financial Institution Routing Number (9 digits)
    c. Type of Account: Checking or Savings
    d. Provider's Account Number with Financial Institution

5. **SUBMISSION INFORMATION**
    a. New Enrollment
    b. Change Enrollment: Use if you need to update the Financial Institution account number or routing number.

6. **AUTHORIZATION**
    a. Authorized Signature: Signature of the person who is authorized to initiate, modify or terminate EFT enrollment.
    b. Printed Name: The printed name of the person signing the form.
    c. Submission Date: The date the form is completed and mailed or faxed to Fulcrum.
    d. Requested EFT Start/Change/Cancel Date: The date the change is intended to take place if different than the submission date.

7. **IF YOU ARE MISSING AN EFT PAYMENT:** If you have received an electronic Remittance Advice (RA) but not the corresponding EFT payment, please contact our Accounting department at 1-866-714-0524.

8. **HOW TO CONTACT US:** For questions regarding completion of this form or the EFT enrollment process, please call 1-866-714-0524.