ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

(301) 984-1440
(800) 638-6589
Fax: (301) 984-4148
Email: PEFT@SambaPlans.com

1. REASON FOR SUBMISSION

Reason for Submission:

- ❑ New EFT Enrollment
- ❑ Change to Current EFT Enrollment
  (e.g. account or bank changes)
- ❑ Cancel EFT Enrollment
- ❑ Check here if EFT payment is being made to the Home Office of Chain
  (Attach letter authorizing EFT payment to Chain Home Office)

Since your last EFT authorization agreement submission, have you had a:

- ❑ Change of ownership, and/or
- ❑ Change of Practice Location?
  If you checked either change of ownership or change of practice location, you must submit a change of information prior to or accompanying this EFT Authorization Agreement submission.

2. ACCOUNT HOLDER INFORMATION

Provider/Supplier/Biller Legal Name

Chain Organization Name or Home Office Legal Name *(if different from Chain Organization Name)* Account

Account Holder's Practice Location Street Address

Account Holder's Practice Location City	Account Holder's Practice Location State	Account Holder's Practice Location Zip Code

Tax Identification Number (❑ SSN or ❑ EIN)

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National Provider Identifier (NPI)

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National Provider Identifier (NPI)

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3. FINANCIAL INSTITUTION INFORMATION

Financial Institution's Name

Financial Institution's Street Address

Financial Institution's City	Financial Institution's Location State	Financial Institution's Zip Code

Financial Institution's Telephone Number	Financial Institution's Contact Person

Financial Institution Routing Number

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Provider's/Supplier's/IPP Entity's Account Number with Financial Institution

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Type of Account *(check one)*

☐ Checking Account ☐ Savings Account

PLEASE NOTE: In accordance with section 1104 of the Affordable Care Act, enrollment of electronic fund transfer (EFT) is for electronic fund transfer authorization only.

4. ACCOUNT HOLDER CONTACT PERSON

Contact Person's Name	Contact Person's Title
Contact Person's Telephone Number	Contact Person's E-mail Address

5. AUTHORIZATION

I hereby authorize SAMBA Health Benefit Plan to initiate credit entries, to the account indicated above. I hereby authorize the financial institution/bank named above to credit and/or debit the same to such account. SAMBA Health Benefit Plan may assign its rights and obligations under this agreement to SAMBA Health Benefit Plan's designated fee-for-service contractor. SAMBA Health Benefit Plan may change its designated contractor at SAMBA Health Benefit Plan's discretion.

If payment is being made to an account controlled by a Chain Home Office, the Provider of Services hereby acknowledges that payment to the Chain Office under these circumstances is still considered payment to the Provider, and the Provider authorizes the forwarding of payment to the Chain Home Office.

If the account is drawn in the Physician's or Individual Practitioner's Name, or the Legal Business Name of the Provider/Supplier entity, the said Provider/Supplier entity certifies that he/she has sole control of the account referenced above, and certifies that all arrangements between the Financial Institution and the said Provider/Supplier entity are in accordance with all applicable regulations and instructions.

This authorization agreement is effective as of the signature date below and is to remain in full force and effect until SAMBA Health Benefit Plan has received written notification from me of its termination in such time and such manner as to afford SAMBA Health Benefit Plan and the Financial Institution a reasonable opportunity to act on it. SAMBA Health Benefit Plan will continue to send the direct deposit to the Financial Institution indicated above until notified by me that I wish to change the Financial Institution receiving the direct deposit. If my Financial Institution information changes, I agree to submit to SAMBA Health Benefit Plan an updated EFT Authorization Agreement.

6. SIGNATURE

Authorized/Delegated Official Name (Print)	Authorized/Delegated Official Telephone Number
Authorized/Delegated Official Title	Authorized/Delegated Official E-mail Address
Authorized/Delegated Official Signature *(Must be original signature)*	Date

<u>Please return this completed EFT Authorization Agreement to:</u>

Mail: SAMBA Health Benefit Plan
11301 Old Georgetown Road
Rockville, MD 20852-2800

Fax: (301) 984-4148
Email: PEFT@SambaPlans.com

PLEASE REMEMBER TO INCLUDE:

A confirmation of account information on bank letterhead or a voided check. When submitting the documentation, it should contain the name on the account, electronic routing transit number, account number and type. If submitting bank letterhead, the bank officer's name and signature is also required. This information will be used to verity your account number.