



**Capitation Payment  
Electronic Funds Transfer (EFT) Authorization Agreement**

New     
  Change     
  Cancel

<b>Provider Group/IPA Name</b>		<b>Tax ID</b>	
<b>Street</b>	<b>City</b>	<b>State</b>	<b>Zip</b>
<b>Provider, IPA or MSO Contact</b> (Please circle one)	<b>Phone</b>	<b>Fax</b>	<b>Email</b>
<b>Contact Title</b>	<b>MSO Name, if any</b>		
<b>Financial Institution</b>		<b>Phone</b>	
<b>Account Name</b>	<b>** ABA/Routing No.</b>		
<b>Account Type:</b> <input type="checkbox"/> Checking <input type="checkbox"/> Saving	<b>** Account No.</b>		
** Please include a confirmation of account information on bank letterhead or a voided check for account verification. If submitting bank letterhead, the bank officer's name and signature is required.			

Attach Voided Check Here

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**VOIDED CHECK COPY**

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I hereby authorize Imperial Health Plan of California, Inc. (IHPC) to initiate credit entries to the account at the financial institution indicated above. This agreement will remain in effect until I notify IHPC of any changes or corrections to my bank account information or until IHPC notifies me that this service has been terminated. I understand that it will take approximately four weeks to process my enrollment, change or cancellation request from the date received by IHPC. I understand that IHPC reserves the right to reverse direct deposit of funds paid in error.

\_\_\_\_\_  
Approved Provider Signature (Account Holder)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Request Start Date (Month/Year)

***Please send your completed form along with the voided check or bank letter to IHPC by email at***

***[PDM@imperialhealthholdings.com](mailto:PDM@imperialhealthholdings.com)***