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## AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER (EFT)

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**WPS Commercial providers must be submitting electronically and be receiving Electronic Remittance Advise (ERA) in order to receive Electronic Funds Transfer (EFT).**

**\*Note: This does not include WPS Commercial Family Care Programs.**

Please complete the attached form to enroll for Electronic Funds Transfer for WPS Commercial.

Return completed forms, with original signatures, to:

**Wisconsin Physicians Service  
Electronic Data Service  
P.O. Box 8128  
1717 W. Broadway  
Madison, WI 53708-8128**

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### INSTRUCTIONS FOR COMPLETING THE EFT AUTHORIZATION AGREEMENT

All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any TRICARE direct deposits are made.

#### **PART I – REASON FOR SUBMISSION**

Indicate if this is a new EFT authorization or change to your existing account information. If you are authorizing EFT payments to the home office of a chain organization of which you are a member, you must attach a letter authorizing the contractor to make payment due the provider of service to the account maintained by the home office of the chain organization. The letter must be signed by an authorized official of the provider of service and an authorized official of the chain home office.

#### **PART II – IDENTIFICATION DATA**

**Line 1** – Enter the name of the physician or individual practitioner or the legal business name of the provider/supplier as reported to the Internal Revenue Service (IRS). The account must be solely in the name of the physician or individual practitioner or in the legal business name of the person or entity.

**Line 2** – Enter the provider's/supplier's legal business name. The account to which EFT payments made must be solely in the name of the physician or individual practitioner or in the legal business name of the person or entity.

**Line 3** – Enter the chain organization's name.

**Line 4** – Enter the home office legal business name if different from the chain organization name.

**Line 5** – Enter the tax identification number as reported to the IRS. If the business is a corporation, provide the Federal employer identification number, otherwise provide your Social Security Number.

**Line 6** – If issued, enter the Medicare identification number assigned by a Medicare fee-for-service contractor. If you are not enrolled in Medicare, leave this field blank.

**Line 7** – Enter the 10 digit NPI number. The NPI is required to process this form.

#### **PART III – DEPOSITORY INFORMATION (Financial Institution)**

**Line 8** – Enter your depository name (this is the name of the bank or qualifying financial institution that will receive the funds).

**Line 9** – Enter the account holder's name.

**Line 10** – Enter the account holder's street address.

**Line 11** – Enter the account holder's city, state and ZIP code.

**Line 12** – Enter the bank or financial institutional telephone number.

**Line 13** – Enter the bank or financial institutional nine-digit routing number.

**Line 14** – Enter the depositor's account number and select the account type.

**If you do not submit this information, your EFT authorization agreement will be returned without further processing.**

#### **PART IV – CONTACT PERSON**

Enter the information for the contact person responsible for this EFT authorization agreement.

#### **PART V – AUTHORIZATION**

**Line 21** – By your signature on this form you are certifying that the account is drawn in the name of the physician or individual practitioner or in the legal business name of the provider or supplier. The provider or supplier has sole control of the account to which EFT deposits are made in accordance with all applicable regulations and instructions. Arrangements between the depository and the provider or supplier are in accordance with applicable regulations and instructions with the effective date of the EFT authorization. You must notify WPS regarding any changes in the account in sufficient time to allow WPS and the depository to act on changes. The EFT authorization form must be signed and dated by the same Authorized Representative. Mail this form with the original signature (no facsimile signatures can be accepted) to WPS.

**WPS COMMERCIAL ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT**

**PART I – REASON FOR SUBMISSION**

- Reason for Submission:  New EFT Authorization
- Revision to Current Authorization (e.g. account or bank changes)
- Chain Home Office:  Check here if EFT payment is being made to the Home Office of Chain Organization (Attach letter Authorizing EFT payment to Chain Home Office)
- EFT Termination Request

**PART II – PROVIDER OR SUPPLIER INFORMATION**

Name

Provider/Supplier Legal Business Name

Chain Organization Name

Home Office Legal Business Name  
(if different from Chain Organization Name)

Tax Identification Number

National Provider Identifier (NPI)

List all physical & billing locations requesting EFT. Attach additional sheet if necessary. Street/City/State/Zip Code

Physical Address	Provider Payment Address
1.	
2.	
3	
4	

**PART III – DEPOSITORY INFORMATION (Financial Institution)**

Depository Name

Account Holder's Name

Account Holder's Address:  
Street

City

State

Zip

Depository Telephone Number

Depository Contact Person

Depository Routing Transit Number (nine digit)

Depository Account Number

Type of Account (check one)  Checking Account  Savings Account

Please include a **voided check**. When submitting the documentation, it should contain the name on the account, electronic routing transit number, account number and type, and, if the information is provided on **bank letterhead**, a bank officer's signature. This information will be used to verify your account number.

**PART IV – CONTACT PERSON**

First Name	Middle Initial	Last Name
Telephone Number		Fax Number (if applicable)
Address Line 1 (Street Name and Number)		
Address Line 2 (Suite, Room, etc.)		
City/Town	State	Zip
E-mail Address		

**PART V – AUTHORIZATION**

**Authorization**

I hereby authorize WPS, hereinafter called the COMPANY, to initiate credit entries, and in accordance with 31 CFR 210.6(f) initiate adjustments for any credit entries made in error (does not include program overpayments) to the account indicated above. I hereby authorize the financial institution/bank named above, hereinafter called the DEPOSITORY, to credit and/or debit the same to such account.

If the account is drawn in the Physician's or Individual Practitioner's Name, or the Legal Business Name of the Provider/Supplier, the said Physician/Provider/Supplier certifies that t he/she has sole control of the account referenced above, and certifies that all arrangements between the DEPOSITORY and the said Physician/Provider/Supplier are in accordance with all applicable WPS regulations and instruction.

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

**Signature Line**

Authorized/Delegated Official Name (Print)

Authorized/Delegated Official Title

Authorized/Delegated Official Signature

Date

Return completed form with original signatures to:

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Electronic Data Services  
P.O. Box 8128  
1717 W. Broadway  
Madison, WI 53708-8128