
AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER (EFT)

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

AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER (EFT)

Reason for Submission: New EFT Authorization
 Revision to Current Authorization (*i.e. account or bank changes*)
 EFT Termination Request

Physician/Provider/Supplier Information

Physician's Name: _____
Provider/Supplier Legal Business Name: _____
Tax ID Number: (*Designate SSN* *or EIN*) ___ ___ ___ ___ ___ ___ ___ ___ ___
Doing Business As Name: _____

Depository Information (Financial Institution)

Depository Name: _____
Account Holder's Name: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Depository Telephone Number: _____
Depository Contact Person: _____
Depository Routing Transit Number (*nine digit*): ___ ___ ___ ___ ___ ___ ___ ___ ___
Depositor Account Number: _____
Type of Account (*check one*): Checking Account Savings Account

Please include a voided check, preprinted deposit slip, or confirmation of account information on bank letterhead with this agreement for verification of your account number.

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: _____