

INSTRUCTIONS ON COMPLETING APPLICATION FORM

Please complete all lines of the application form to ensure accurate claim payment.

The provider number is located on the top of the EOP document which accompanies your check. If you have multiple provider numbers listed, please include all of them.

The bank routing number is the 9 digit number located at the bottom of your check.

Please fax **application form** and a copy of a **VOIDED CHECK** to 412-454-7744 or mail to the following address:

UPMC Health Plan  
Claims Payable Department  
One Chatham Center  
112 Washington Place  
Pittsburgh, PA 15219

**Applications will not be considered if this form is incomplete or not accompanied by a voided check.**

If you have any questions pertaining to the EFT Reimbursement Application, please contact UPMC Health Plan Provider Services at 1-888-876-2756 Monday through Friday from 8:00-5:00.

# UPMC Insurance Services

## Authorization for Electronic Reimbursement by UPMC Health Plan for Medical Services

If you are interested in receiving electronic payments, please complete the form below

Our Company hereby (1) authorizes UPMC Health Plan to make payments for services by EFT, (2) certifies that it has selected the following depository institution, and (3) directs that all such Electronic Funds Transfers be made as provided below

Name of Organization: \_\_\_\_\_

Federal Tax ID Number: \_\_\_\_\_

Organization's UPMC Provider Number: \_\_\_\_\_

Depository Institution: \_\_\_\_\_

Bank Routing Number: \_\_\_\_\_

Account Number: \_\_\_\_\_

Account Name: \_\_\_\_\_

**\*\* Please include copy of VOIDED CHECK for account verification \*\***

Our Company acknowledges and agrees that terms and conditions of all agreements with UPMC Health Plan concerning the method and timing of payment for services shall be amended.

Our Company will give thirty (30) days advance notice in writing to UPMC Health Plan of any changes in its depository institution or other payment instructions.

When properly executed, this Authorization will become effective fifteen (15) days after its receipt by UPMC Health Plan

Dated: \_\_\_\_\_

\_\_\_\_\_  
(Authorized Signature)

\_\_\_\_\_  
(UPMC Health Plan Authorized Signature)

\_\_\_\_\_  
(Print Name)

Michele Sparkenbaugh  
\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Title)

Director, Accounting  
\_\_\_\_\_  
(Title)

\_\_\_\_\_  
(Phone Number)