UPMC Dental *Advantage* UPMC Vision *Advantage*

Our records indicate your company receives paper reimbursement checks from UPMC Insurance Services Division. We ask that you partner with UPMC Insurance Services Division in going GREEN by switching to electronic funds transfer (EFT). By enrolling in EFT, your company will receive reimbursements sooner because the funds will be directly deposited into your bank account. Our Electronic Funds Transfer Authorization form is on the reverse side.

INSTRUCTIONS FOR COMPLETING THE AUTHORIZATION FORM

Please complete all lines of the authorization form to ensure accurate claims payment.

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

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

Please fax the **authorization form** and one copy of a **voided check** to 412-454-7744 or mail them to the following address:

UPMC Insurance Services Division
Claims Payable Department
U.S. Steel Tower
600 Grant Street, 12th Floor
Pittsburgh, PA 15219

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

If you have any questions regarding the EFT Authorization form, please contact UPMC Dental *Advantage* Provider Services at 1-877-648-9609 or UPMC Vision *Advantage* Provider Services at 1-877-648-9621 Monday through Friday from 8 a.m. to 5 p.m.

Electronic Funds Transfer Authorization form for electronic reimbursement by UPMC Insurance Services Division on behalf of UPMC Dental *Advantage* and UPMC Vision *Advantage*

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

Our Company hereby (1) authorizes UPMC Insurance Services Division 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 Health Plan Provider Number: _____

Depository Institution: _____

Bank Routing Number: _____ Checking ❑ Savings ❑

Account Number: _____

Account Name: _____

**** Please include one copy of a VOIDED CHECK for account verification. ****

Our Company acknowledges and agrees that terms and conditions of all agreements with UPMC Insurance Services Division 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 Insurance Services Division.

Dated: _____

_____ _____

(Company Authorized Signature) (UPMC Insurance Services Division Authorized Signature)

_____

(Print Name)

_____ _____

(Title) UPMC Health Plan Finance Manager

_____

(Phone Number)