

UPMC HEALTH PLAN

UPMC Dental *Advantage*

Authorization for Change/Termination of Electronic Funds Transfer by UPMC Health Plan

Fax form and copy of **VOIDED CHECK** to
412-454-7744 or mail to the following address:

UPMC Health Plan
Claims Payable Department
U.S. Steel Tower
600 Grant Street
Pittsburgh, PA 15219

Select One:

Change: Effective Date _____ or Termination: Effective Date _____

_____ hereby authorizes UPMC Health Plan to make the following changes
_____ Company Name
and/or termination regarding the company's Electronic Funds Transfer agreement.

Prior Name of Organization: _____

New Name of Organization: _____

Prior Federal Tax ID Number: _____

New Federal Tax ID Number: _____

Prior Organization's UPMC Provider Number: _____

New Organization's UPMC Provider Number: _____

Prior Depository Institution: _____

New Depository Institution: _____

Prior Address: _____

New Address: _____

Prior Bank Routing Number: _____

New Bank Routing Number: _____

Prior Account Number: _____

New Account Number: _____

Prior Account Name: _____

New Account Name: _____

The above change/termination will become effective 15 days after its receipt by UPMC Health Plan.

Dated: _____

Authorized Signature

UPMC Health Plan Authorized Signature

Print Name

Print Name

Title

Title