



The information concerning your organization's financial institution will be used to make electronic fund transfer (EFT) payments on all claims that are due and approved for payment for the legal business name listed below. Please note that EFT payments can only be sent to checking accounts.

Provider Information

Provider Name/Practice Name: _____

Address: _____

City: _____State: _____Zip Code: _____

Provider Federal Tax Identification Number (TIN): _____

Provider Contact Name and Title: _____

Telephone Number: _____

Email Address for Remittance/EOB: _____

Financial Institute Information

Financial Institute Name: _____Telephone: _____

Address: _____

City: _____State: _____Zip code: _____

Financial Institution Routing Number: _____

Financial Institution Account Number: _____

Reason for Submission

_____New Enrollment __Change Enrollment ___Cancel Enrollment

AUTHORIZING SIGNATURE: By signing this document, you are authorizing EFT payments to be made to you on behalf of Behavioral Health Systems, Inc to be sent to the above account.

Written Signature of Person submitting Enrollment: _____

Printed Name of Person submitting Enrollment: _____

Submission Date: _____

Please return completed form to bhs_accounting@TELUSHealth.com and include a voided check or bank letter with the completed form in order to process.