First MEDICAL HEALTH PLAN, INC.

Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA) Authorization Form

All fields must be completed. Forms with incomplete or invalid information cannot be processed.

Section I. Reason for Submission: Please select only one

☐ **New EFT Authorization**- Select the business line	☐ **Commercial**	☐ **GHP/Vital**
☐ **Request a Change**		
☐ **EFT Cancellation-** Enclose a letter with a brief explanation of the cancellation reason.		

Section II. Provider Information:

Provider Name:	**IMC Provider Number:** *If applicable*
Doing Business As (DBA) Name:	

Provider Mailing Address:

Street:	**City:**	
State:	**PO Box:**	**Zip Code:**

Provider Personal Contact Information:

Telephone Number:	**Email Address:**

Provider Identifiers:

Provider Federal Tax Identification Number (TIN):	**National Provider Identifier (NPI):**

Provider Contact Office Information:

Provider Contact Name:	**Relation with the Provider:**
Telephone Number:	
Fax Number:	**Email Address:**

Clearinghouse Information:

Assigned Authority:	**Trading Partner ID:**

Section III. Financial Institution Information:

Please include a confirmation of account information on bank letterhead or a Voided Check. When submitting the documentation, it should contain the name on "as is" on the account, electronic routing transit number, account number and type of account. If submitting bank letterhead, the bank officer's name, telephone number and signature is also required. This information will be used to verify your account number. Please Note: In accordance with section 1104 of Affordable Care Act, enrollment of electronic fund transfer (EFT) is for electronic fund transfer authorization only. EFT enrollment does not constitute enrollment as a provider.

Financial Institution Name:

Financial Institution Address:		
Financial Institution Routing Number:		
Financial Institution Provider's Account Number:		
Financial Institution Provider's Account Type:	☐ **Checking Account**	☐ **Savings Account**

Section IV. Authorization and Signature:

I hereby authorize First Medical Health Plan, Inc., to initiate entire credits and/or adjustments for any duplicate or erroneous credits made to previously mentioned account. I hereby authorize the Financial Institution previously mentioned to make any credits and/or debits made by First Medical Health Plan, Inc., of the previously mentioned account. I understand that this authorization form will be part of the Terms and Conditions Agreement and will be included signed as part of this authorization form. I certify that the previously mentioned account is drawn in the name of the physician or individual practitioner or the legal business name of the provider or supplier. I certify that I have sole control of the previously mentioned account in which First Medical Health Plan, Inc., will made the EFT deposits and that this account complies with all applicable Federal and State Laws and Regulations.

Printed Name of the person submitting the EFT and ERA Authorization Form:	
Printed Title of the person submitting the EFT and ERA Authorization Form:	
Provider Signature:	**Submission Date:**

************************DO NOT WRITE BELOW THIS LINE************************

First Medical Health Plan, Inc., and International Medical Card, Inc., Internal Use Only

Receipt Date:	☐ ***Completed***	☐ ***Lack of Information***
Completion Date:	***Sending Notification Date:***	
Completed by:	***Sent by:***	

***** Please complete and signed this EFT and ERA Authorization Form and send it with the requested letters to First Medical Health Plan, Inc., to the address, fax or email provided in the Instructions on how to Complete and Send the EFT and ERA Authorization Form.**

Instructions to Complete and Send the Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA) Authorization Form

Please read carefully before completing the EFT and ERA Authorization Form

Section I. Reason for Submission:

In this section you must select only one of the following alternatives as reason to complete the EFT and ERA Authorization Form:

- **New EFT Authorization**: Select this alternative if you are requesting the Electronic Fund Transfer for first time and select the business line from which you want to receive this transfer.

- **Request a Change**: Select this alternative if you want to change your account information or if you change your clearinghouse. If you are a member of any Central or home Office of a Chain Organization and you want to authorize First Medical Health Plan, Inc., to transfer payments due to your services, to your account with the Central or home Office of a Chain Organization, you must attach to the EFT and ERA Authorization Form a letter signed by an authorized official (CFO, CEO or by the owner, if applicable) authorizing the EFT deposits.

- **EFT Cancellation**: Select this alternative if you want to cancel the prior-authorization submitted due to any circumstance. If you select this alternative, please attach to the EFT and ERA Authorization Form a letter with a brief explanation of the cancellation reason.

Section II. Provider Information:

In this section you must provide all information related to your personal identification and contact information.

- **Provider Name**: Please provide your complete legal name.

- **IMC Provider Number**: The internal number assigned by International Medical Card, Inc., to identify the provider. It's optional to provide this number.

- **Doing Business As (DBA) Name**: The DBA is a legal term used in the United States to mean that the trade name or business name under which the business or operation is conducted and presented to the public is not the legal name of the legal person who actually own it and are responsible for it. Please provide the complete legal name under which you offer your services as healthcare provider.

- **Provider Mailing Address**: Please provide your postal mail address. Complete the space provided in the sections of Street, City, State, PO Box and Zip Code.

- **Provider Personal Contact Information**: Please provide your personal phone number, your office phone number and your email address. Complete the space provided in the sections of Telephone Number and Email Address.

- **Provider Identifiers**: Please provide your identifiers numbers as healthcare provider. Complete the space provided in the sections of Provider Federal Tax Identification Number and National Provider Identifier. The Provider Federal Tax Identification Number and National Provider Identifier means:

    ↳ **Provider Federal Tax Identification Number (TIN)**- A federal tax identification number used to identify a business entity, also known as Employer Identification Number (EIN).

    ↳ **National Provider Identifier (NPI)**- A unique 10-digit identification number for covered healthcare providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under the Health Insurance Portability and Accountability Act (HIPAA).

- **Provider Contact Office Information**: Please provide the information of the personnel in charge to handling the EFT and ERA issues. Complete the space provided in the sections of Provider Contact Name, Relation with the Provider, Telephone Number, Fax Number and Email Address.

- **Clearinghouse Information**: Please provide your Clearinghouse information, if applicable. Complete the space provided in the sections of Assigned Authority and Trading Partner ID. The Assigned Authority and Trading Partner ID/Clearinghouse Number ID means:

    ↳ **Assigned Authority**- Name of the Clearinghouse that provides financial services to the provider.

    ↳ **Trading Partner ID/Clearinghouse Number ID**- The provider's submitted ID assigned by the Clearinghouse.

Section III. Financial Institution Information:

Please include a confirmation of account information on bank letterhead or a Voided Check. When submitting the documentation, it should contain the name on "as is" on the account, electronic routing transit number, account number and type of account. If submitting bank letterhead, the bank officer's name, telephone number and signature is also required. This information will be used to verify your account number. Please Note: In accordance with section 1104 of Affordable Care Act, enrollment of electronic fund transfer (EFT) is for electronic fund transfer authorization only. EFT enrollment does not constitute enrollment as a provider.

- **Financial Institution Name**: Please provide the financial institution official name.

- **Financial Institution Address**: Please provide the Street, City, State, PO Box and Zip Code of your financial institution.

- **Financial Institution Routing Number**: A bank routing number is a 9-digit number that identify the financial institution associated with your account. Please provide your financial institution routing number in the space provide.

- **Financial Institution Provider's Account Number**: Please provide your financial account number where you want to receive your EFT payments.

- **Financial Institution Provider's Account Type**: Please specify if your financial account is a Checking account or Saving account in the space provide.

Section IV. Authorization and Signature:

- In this section you must certify that all information provided in the EFT and ERA Authorization Form is accurate and that you authorize First Medical Health Plan, Inc., to transfer payments due to your services via EFT deposits. Please provide the printed name and printed title of the person submitting the EFT and ERA Authorization Form and the date that you submit EFT and ERA Authorization Form.

Important: The EFT and ERA Authorization Form must be signed by the provider.

To complete your EFT and ERA request it's important that:

- After completing all applicable sections of the EFT and ERA Authorization Form, you must send the completed form with the requested letters to First Medical Health Plan, Inc., at:

  ↳ First Medical Health Plan, Inc.
  Attention: Electronic Fund Transfer (EFT)
  PO Box 191580
  San Juan Puerto Rico 00919-1580

- If you need an expedite processing, you must send the completed form with the requested letters to First Medical Health Plan, Inc., at:

  ↳ Via Fax: 787-300-3936
  ↳ Via Email: fm-eftpayment@firstmedicalpr.com

Commercial Providers:

If you have any questions about completing the EFT and ERA Authorization Form or you need status of your request, please contact our Provider Service Department at 787-878-6909 Monday through Friday from 8:00 a.m. to 5:00 p.m., or visit the International Medical Card, Inc., website at www.intermedpr.com.

Government Health Plan/Vital Plan Providers:

If you have any questions about completing the EFT and ERA Authorization Form or you need status of your request, please contact our Provider Service Department at 1-844-347-7802 Monday through Friday from 7:00 a.m. to 7:00 p.m., or visit the First Medical Health Plan, Inc., website at www.firstmedicalvital.com.

Important Note: In accordance with the section 1104 of the Affordable Care Act: The enrollment of EFT is only for EFT authorization. EFT enrollment does not constitute enrollment as a provider.