## **Electronic Funds Transfer (EFT) Authorization Agreement**

This document is intended to establish Electronic Funds Transfer (EFT) enrollment. This document shall become effective when submitted by the provider. The responsibilities and obligations contained in this document will remain in effect as long as claims are submitted to WPS. Either party may terminate this arrangement by giving the other party thirty (30) days written notice of its intent to terminate. In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.

DEG1: Provider Informa	ntion		
Provider Name:			
Doing Business As Name (DBA):			
Provider Address			
Street:	City:	State/Province:	
Zip Code/Postal Code:	Country Code:		
DEG2: Provider Identifie	rs Information		
Provider Identifiers			
Provider Federal Tax Identification 1	Number (TIN) or Employer Identific	eation Number (EIN):	
National Provider Identifier (NPI)	):		
Other Identifier(s)			
Assigning Authority:	Trading Partner ID:		
Provider License Number:	License	License Issuer:	
Provider Type:	Provide	Provider Taxonomy Code:	
DEG3: Provider Contact	Information		
Provider Contact Name:			
Title:			
Telephone Number:	Teleph	elephone Number Extension:	
Email Address:	Fax Nu	ımber:	

Provider Agent Information Provider Agent Name:	nation		
Agent Address			
Street:	City:	State/Province:	
Zip Code/Postal Code:	Country Code:		
Provider Agent Contact Name:		Title:	
Telephone Number:	Telephor	Telephone Number Extension:	
Email Address:	Fax Num	nber:	
DEG5: Federal Agency Infor	mation		
Federal Program Agency Name:			
Federal Program Agency Identifier:			
Federal Agency Location Code:			
DEG6: Retail Pharmacy Infor	mation		
Pharmacy Name:			
Chain Number:			
Parent Organization ID:			
Payment Center ID:			
NCPDP Provider ID Number:			
Medicaid Provider Number:			
DEG7: Financial Institution	nformation		
Financial Institution Name:			
Financial Institution Address:			
Street:	City:		
State/Province:	Zip Cod	Zip Code/Postal Code:	
Financial Institution Telephone Number:		Telephone Number Extention:	

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Financial Institution Rou	uting Number:		
Type of Account at Fina	ncial Institution:		
Provider's Account Num	nber with Financial Institution:		
Account Number Lin	kage to Provider Identifie	r	
Provider Tax Identification	on Number (TIN):		
National Provider Identi	fier (NPI):		
DEG8: Submission	n Information		
Reason for Submission:	O New Enrollment	○ Change Enrollmen	nt Cancel Enrollment
Include with Enrollment Submission:		O Voided Check	O Bank Letter
Authorized Signatu	re		
Printed Name of Person	Submitting Enrollment:		
Submission Date:	Requested	d EFT Start/Change/Cance	el Date:
In order to determine to email using the following the following the following the following the following the following the second section of the following	the status of this enrollment, ing information: Tricare for Life	Veteral VAPCC	department by phone or ns Administration – VA C Region 3, VAPCCC Region 5A, C Region 5B and VAPCCC Region 6
Wisconsin Physicians Services Electronic Data Services P.O. Box 8128 1717 West Broadway Madison, WI 53713	Wisconsin Physicians Electronic Data Serv P.O. Box 8128 1717 West Broadwa Madison, WI 53713	vices Wiscon Electro P.O. Box	nsin Physicians Service onic Data Services x 8128 Vest Broadway

Email: edi@wpsic.com