new mexico health connections

Electronic Funds Transfer (EFT) Authorization Agreement

Type of Authorization (check one): ☐ **NEW** ☐ **CHANGE**

Taxpayer ID# (TIN): _____

☐ Please check this box if you choose **not** to participate, and then return this Agreement to provider.services@mynmhc.org.

Legal Business Name	**Group NPI Number**	**Individual Provider NPI Number**
Provider Accounting Address	**Phone Number**	**Fax Number**
Bank Name	**ABA/Transit Number (bank routing number)**	
Bank Street Address	**Account Number**	
Bank City/State/Zip	**Provider Email Address**	
Bank Phone Number	**Type of Account (check only one)**	
	☐ Checking ☐ Savings **PLEASE ATTACH A VOIDED CHECK.**	

I (we) hereby authorize New Mexico Health Connections (NMHC) to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I am (we are) responsible for the validity of the information on this form. If NMHC erroneously deposits funds into my (our) account, I (we) authorize NMHC to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay cycle.

I (we) agree to comply with all certification and credentialing requirements of NMHC and the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by NMHC or its authorized affiliate(s) or subcontractor(s). I (we) understand that payment of claims will be made from federal and state funds, and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

I (we) will continue to maintain the confidentiality of records and other information relating to clients covered by programs offered through NMHC in accordance with applicable state and federal laws, rules, and regulations.

Authorizing Signature _____ Date Signed _____

Printed Name _____ Title of Signatory _____

For the convenience of having direct deposit, you must be willing to download your EOB/EOP directly from our website, www.mynmhc.org. No paper copies will be mailed.

RETURN THIS AGREEMENT TO:
New Mexico Health Connections
P.O. Box 36719
Albuquerque, NM 87176

OR EMAIL THIS AGREEMENT TO: provider.services@mynmhc.org

Forms must be mailed or scanned and sent by email. Faxed copies WILL NOT be acceptable due to readability.