

LONE STAR

MEDICAL GROUP, PLLC

Capitation Payment Electronic Funds Transfer (EFT) Authorization Agreement

New Change Cancel

Provider Group/IPA Name		Tax ID	
Street	City	State	Zip
Provider, IPA or MSO Contact (Please circle one)	Phone	Fax	Email
Contact Title	MSO Name, if any		
Financial Institution		Phone	
Account Name	** ABA/Routing No.		
Account Type: <input type="checkbox"/> Checking <input type="checkbox"/> Saving	** Account No.		
** Please include a confirmation of account information on bank letterhead or a voided check for account verification. If submitting bank letterhead, the bank officer's name and signature is required.			

Attach Voided Check Here

VOIDED CHECK COPY

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I hereby authorize Imperial Health Plan of California, Inc. (IHPC) to initiate credit entries to the account at the financial institution indicated above. This agreement will remain in effect until I notify IHPC of any changes or corrections to my bank account information or until IHPC notifies me that this service has been terminated. I understand that it will take approximately four weeks to process my enrollment, change or cancellation request from the date received by IHPC. I understand that IHPC reserves the right to reverse direct deposit of funds paid in error.

Approved Provider Signature (Account Holder)

Date

Printed Name

Request Start Date (Month/Year)

Please send your completed form along with the voided check or bank letter to IHPC by email at

PDM@imperialhealthholdings.com