Louisiana

# Electronic Funds Transfer (EFT) Termination/Change Form

To **stop** receiving your Blue Cross and Blue Shield of Louisiana payments via electronic funds transfer (EFT) or to **change** your EFT information, please complete the following information:

## TERMINATION/CHANGE REQUEST

- ❑ Please terminate me from the EFT program.
- ❑ Please change my EFT information as reflected below.

## CONSENT

If changing my EFT information, I hereby authorize Blue Cross and Blue Shield of Louisiana, hereinafter called COMPANY, to initiate credit entries, and in accordance with LSA R. S. 250.38 to initiate adjustment for any credit entries made in error to the account indicated below.

If changing my EFT information, I hereby authorize the financial institution/bank named below, hereinafter call BANK, to credit and/or debit the same to such account. I am aware that the weekly Provider Payment Register will no longer be mailed to our office, but it will be available for viewing and/or printing in the iLinkBLUE *Provider Suite*.

## PROVIDER INFORMATION

| Provider Name | | |
|---|---|---|
| Provider Address: Street | | |
| City | State/Province | Zip Code/Postal Code |

## PROVIDER IDENTIFIERS INFORMATION

| Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) | |
|---|---|
| National Provider Identifier (NPI) | Group NPI (if applicable) |

## PROVIDER CONTACT INFORMATION

| Provider Contact Name | Title | |
|---|---|---|
| Telephone Number | Email Address | Fax Number |

## RETAIL PHARMACY INFORMATION

| Pharmacy Name |
|---|
| NCPDP Provider ID Number |

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## FINANCIAL INSTITUTION INFORMATION

| Former Financial Institution Name | | |
|---|---|---|
| Former Type of Account at Financial Institution | Former Financial Institution Account Number | Former Financial Institution Routing Number |
| New Financial Institution Name | | |
| New Type of Account at Financial Institution | New Financial Institution Account Number | New Financial Institution Routing Number |

New Account Number Linkage to Provider Identifier

- ❑ Provider Tax Identification Number (TIN): _____
- ❑ National Provider Identifier (NPI): _____

## SUBMISSION INFORMATION

Include with Enrollment Submission

- ❑ Voided Check *(temporary checks are not accepted)*

  or

- ❑ Bank Letter

Authorized Signature

❑ For change request:
This information is to remain in full force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and BANK a reasonable opportunity to act on it. An EFT Termination/Change Form must be completed if **any** of the above information changes.

❑ For termination request:
This information is to be removed from my account and remain in full force and effect until COMPANY has received written notification from me of new EFT information.

_____
Written Signature of Person Submitting Enrollment

_____
Printed Name of Person Submitting Enrollment

_____
Submission Date

## RETURN INFORMATION

Please return your completed Electronic Funds Transfer Enrollment Form in one of the following ways:

Mail to: Attn: NAD/BCBSLA
P.O. BOX 98029
Baton Rouge, LA 70898-9029

Email: network.administration@bcbsla.com

Fax: (225) 297-2750

If you have any questions about this form or your EFT enrollment status, please contact Network Operations at:

Phone: 1-800-716-2299, option 3

Email: network.administration@bcbsla.com