One Monarch Place · Suite 1500
Springfield, MA 01144-1500
hne.com

HNE PROVIDER COMPENSATION ELECTRONIC FUNDS TRANSFER FORM (EFT)

The undersigned Provider hereby authorizes and requests Health New England, Inc. (HNE) to effect payment for all amounts owed to the Provider by HNE as such amounts become payable. Payment shall be made by initiating entries to the Provider's account in the bank or financial institution indicated below. The Provider authorizes and requests said bank or financial institution to credit the same to such account.

Bank Name: _____

Name as it appears on account: _____

Bank Address: _____

City State Zip

Account Number: _____

Exactly as it appears on Check or Savings Statement

Type of Account (select one): ☐ Checking Account ☐ Savings Account

Routing Number ☐☐☐☐☐☐☐☐☐

Authorized Signature: _____

This authorization is active as of two weeks after HNE receives the request and shall remain in effect until terminated. The Provider may terminate this authorization without cause by giving 15 days prior written notice to HNE. HNE may terminate this authorization without cause at any time.

I agree that if unearned or erroneous payment is credited to my account by HNE, I will immediately repay HNE the full amount of such unearned or erroneous pay. I also agree to allow an automatic reversal of any deposits made in error.

Provider Contact Information

Provider Name: _____

Contact at Provider's office: _____

Provider Address: _____

E-mail address of Provider: _____

Phone number of Provider: _____

Provider's NPI Number: _____

Date : _____

Please return completed form to:
Health New England, Inc.
Suite 1500, Springfield, MA 01144
Attn: Accounting
Fax: 413.233.2730