Health Alliance Plan
Direct Deposit Application (EFT)

Electronic Funds Transfer (EFT) is a payment option offered to providers/vendors of Health Alliance Plan. You may elect to have your payments electronically deposited to the financial institution of your choice. Your Remittance Advice (RA) representing this payment will be forwarded to the address on record. Payment(s) can be directed to your United States bank of choice, the U.S. Bank must be an ACH member.

How to Enroll

- The provider/vendor completes the EFT application. (The U.S. bank routing number or ABA number can be obtained from the customer's account officer at the banking institution).
- An authorized signer for the company must sign the application and attach a voided check or bank letter confirmation.
- The provider/vendor submits the completed form to AP/Disbursements. (see below for how to submit)

Account Validation

- Health Alliance Plan will send an electronic prenotification (prenote) file to the Receiving Depository Financial Institution (RDFI) to ensure that the Receiver's bank account information is correct. A prenote is a one-cent entry that tests the accuracy of account data at the RDFI before live entries are sent. Once HAP has received confirmation from the bank that the transfer was a success, all future payments will be electronically transferred. Any provider/vendor payment inquiries should be directed to Accounts Payable, via email at accountspayable@hap.org.

Provider/Vendor – Electronic Funds Transfer (EFT)

Provider/Vendor Tax ID No (TIN/EIN): _____

Provider/Vendor Name: _____

Provider/Vendor Address: _____

City, State, & Zip: _____

EFT Contact Name & Phone Number: _____

E-mail address (Required for notification): _____

TYPE (mark with an x): ☐ **New Enrollment** ☐ **Change Enrollment** ☐ **Cancel Enrollment**

Name of Financial Institution: _____

City, State: _____

U.S. Bank Routing Number: _____ (Mandatory 9 digits)

Checking Account Number: _____

Include with enrollment submission: ☐ **Voided Check** ☐ **Bank Letter**

*****REQUIRED (Please Complete)**:*** ***Will payments made via Direct Payment pursuant to this Authorization be funded/forwarded to a foreign (non-U.S.) institution? Yes (If yes, please complete the FOREIGN FINANCIAL INSTITUTION segment*)***

Mail, Fax, or E-mail Completed Form to:
Health Alliance Plan of Michigan
AP/Disbursements
2850 W. Grand Blvd
Detroit, Michigan 48202
E-mail: accountspayable@hap.org
Fax No: 313-664-5362

_____
(EFT Authorized Signature) (Date)

_____
(EFT Authorized Name and Title) (Please Print)

****FOREIGN FINANCIAL INSTITUTION:*** Institution Name: _____ Branch: _____
City: _____ State/Province: _____ Postal Code: _____ Country: _____
Identification Number: _____Account Number: _____

EFT Enrollment Process to Support Healthcare Claim Payments and Remittance Advices

Instructions for completing the EFT Enrollment form

Please type or print legibly
Please allow 4 weeks for the enrollment process which includes pre-note verification. If after 4 weeks you do not start receiving EFT payments, you may contact the AP team at accountspayable@hap.org.

For questions about the paper or electronic enrollment process, please call the AP Team at accountspayable@hap.org

Provider Information – please fill out completely

Provider Name – Complete legal name of institution, corporate entity, practice or individual provider.
Provider Address -
- Street – the number and street name where a person or organization can be found
- City – City associated with the provider address field
- State/Province – ISO 3166-2 two-character code associated with the state/Province/Region of the applicable Country
- Zip Code/Postal Code – System of postal-zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities.

Provider Identifiers

Provider Federal Tax Identification Number (TIN) – A Federal Tax Identification Number, also known as an Employer Identification number (EIN), is used to identify a business entity.

Provider Contact Information

Provider Contact Name – Name of a contact in provider office for handling EFT issues
Telephone Number – Associated with contact person
Email Address – An electronic mail address at which the health plan might contact the provider
Fax Number – A number at which the provider can be sent facsimiles

Financial Institution Information

Financial Institution Name – Official name of the provider's financial institution
Financial Institution Routing Number – A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited.
Provider Account Number with Financial Institution – Provider's account number at the financial institution to which EFT payments are to be deposited

Reason for Submission – Must select one from below

New Enrollment **Change Enrollment** **Cancel Enrollment**

Include with Submission: Must select one from below, note that a copy of a voided check is needed if checking account is being used.
- **Voided Check** – A voided check is attached to provide confirmation of Identification/Account Numbers
- **Bank Letter** – A letter on bank letterhead that formally certifies the account owners routing and account numbers

Authorized Signature – The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment.

Written Signature of Person Submitting Enrollment – A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity.
Printed Name of the Person Submitting Enrollment – The legibly printed name of the person signing the form; may be used with electronic and paper-based manual enrollment.
Printed Title of Person Submitting Enrollment - The legibly printed title of the person signing the form; may be used with electronic and paper-based manual enrollment.
Submission Date – The date on which the enrollment is submitted.
Requested EFT Start/Change/Cancel Date – The date on which the requested action is to begin.
Fax the completed form to – 313-664-5362
Researching Missing/Late Files
EFT payment(s) that have not been received after 4 business days of receipt of the deposit e-mail, can be researched by calling the Accounts Payable department at accountspayable@hap.org.