



MASS ADVANTAGE

Electronic Funds Transfer (EFT) Agreement

Date of Submission: _____

Reason for Submission: New EFT Enrollment Change EFT Enrollment

Group Information (all fields required):

Practice Name (complete legal name of institution, corporate entity, practice, or individual provider)				
Tax Identification Number (IRS#)			NPI	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Primary Billing Street Address	City	State/Province	Zip Code	Country
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Contact Information (all fields required):

Primary contact name and Email (for EFT issues)
<input type="text"/>
Secondary Contact Name and Email (for EFT issues)
<input type="text"/>

EFT – Direct Deposit / Provider’s Financial Institution Information (all fields required):

Financial Institution Name
<input type="text"/>
Account Number (where funds will be deposited)
<input type="text"/>
Routing/ABA Number (financial institution’s 9-digit routing number found on a check, NOT a deposit slip)
<input type="text"/>

Please return to Provider Relations at provider.relations@massadvantage.com. You may also return the form by fax, 774-272-9330, ATTN: Provider Relations.