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**		
Primary Billing Street Address	**City**	**State/Province**	**Zip Code**	**Country**

Contact Information (all fields required):

Primary contact name and Email (for EFT issues)
Secondary Contact Name and Email (for EFT issues)

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

Financial Institution Name
Account Number (where funds will be deposited)
Routing/ABA Number (financial institution's 9-digit routing number found on a check, NOT a deposit slip)

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

Please register for Electronic Remittance Advice (ERA) through Change HealthCare.
PAYER NAME: MASS ADVANTAGE
PAYER ID: 86220

Last updated: 2/9/2023