A Program of All-Inclusive Care for Adults 55+
Sponsored by CenterLight Healthcare

EFT/ACH Request Form

☐ ACH Electronic Funds Transfer

GENERAL INFORMATION:

Requested Effective Date: ______________________________

Provider Name: ______________________________

Provider Contact Name: ______________________________

Contact Phone ____________________ Contact Email: ____________________

Tax ID Number: ______________________________

All Applicable Billing/Pay to NPI: ______________________________

BANK INFORMATION:

ACH Routing Number (ABA #): ______________________________

Bank Account Number: ______________________________

Bank Name: ______________________________

Bank Address: ______________________________

Check one: ☐ Savings ☐ Checking

RETURN THIS COMPLETED FORM TO ONE OF THE FOLLOWING:

Fax: 1-608-729-8995
Email: CenterLightFax@ppi.com
Or mail directly to: CenterLight Healthcare, PO Box 21546, Eagan, MN 55121

Form Completed By: ____________________ Date: ____________________

(1) Minimum of 14 business days is needed to process a request from date received.
(2) Please attach a copy of a voided check and a W9.
(3) Type in blue or black ink.