Hill Physicians
Your health. It's our mission.

Electronic Funds Transfer Verification/Release

I hereby authorize Hill Physicians Medical Group to transfer my claims payments into the account listed below each week. I understand that it is **my** responsibility to provide Hill Physicians with the correct account information. If your bank account information changes, please notify us of the new bank numbers at least 2 weeks prior. Please attach a voided check from the account you wish the funds to be transferred. If a voided check is not available please submit a letter from your Bank with your name, Bank's Name, Account # and Routing #.

Practice Name:	**Tax Identification Number:**	**NPI Number:**
Authorized Representative Name (Printed):	**Authorized Representative Signature:**	
Phone Number:	**Email Address:**	**Hill inSite Username:**

Please check the appropriate section: ☑

☐	**Please begin Electronic Funds Transfer to the following account:** **Account Type: ☐ Checking ☐ Savings ☐ Other (specify) _____**
Routing Number	Account Number
Date:	**Initials:**

☐	**Please change our Electronic Funds Transfer Account to:** **Account Type: ☐ Checking ☐ Savings ☐ Other (specify) _____** **Old Account Number: _____**
Routing Number	Account Number
Date:	**Initials:**	**Effective Date of Change:**

Electronic Funds Transfer set-up may take up to two weeks to take effect.

Please complete this form, print and hand to your *Practice Support Advisor* or send via fax to*:*

East Bay: (925) 743-9492
San Francisco: (925) 743-9492
Solano: (925) 743-9492
San Joaquin: (209) 762-5092
Sacramento: (916) 286-7002

Office Use Only:

Received:		Dictionaries		Roles Table	Task List	Database	FAX	Set up Date:	Date Live:
Date	By	471	9023						