RESET

ELECTRONIC FUND TRANSFER ENROLLMENT FORM for Ancillary Facilities ONLY

This Electronic Funds Transfer Enrollment Form is **ONLY** for the use of Ancillary Facilities that bill services via a UB-04 Claim Form or a HIPAA ANSI X12 837I Institutional Health Care Claims Transaction format.

Ancillary Facilities may email this completed form, along with required supporting documentation, to Ancillary_ProviderNetwork@horizonblue.com, or may mail this information to:

Horizon BCBSNJ
Ancillary Reimbursement/EFT Enrollment
3 Penn Plaza East, PP14K
Newark, NJ 07105-2200

If your organization is an **Ancillary Professional Provider** (*if you bill services via a CMS-1500 Claim Form or a HIPAA ANSI X12 837P Professional Health Care Claims Transaction format*) you must register for EFT online through NaviNet. Visit HorizonBlue.com/EFT for information.

ANCILLARY FACILITY INFORMATION

Provider Name: _____

Provider Address: _____

City: _____ State: _____ ZIP: _____

NPI: _____ Medicare UPIN: _____

Tax ID (TIN) or Employer ID Number (EIN): _____

Ancillary Facility Provider Type (*all must submit claims via either UB04 or 837I format*):

- ☐ Acute Rehabilitation Center
- ☐ Ambulance Provider
- ☐ Ambulatory Surgery Center
- ☐ Behavioral Health/Substance Abuse Facility
- ☐ Comprehensive Rehabilitation Center
- ☐ Dialysis Center
- ☐ Home Health Care Agency
- ☐ Hospice Providers
- ☐ Lithotripsy Center
- ☐ Skilled Nursing Facility
- ☐ Other, please explain: _____

ANCILLARY FACILITY CONTACT INFORMATION

Name: _____ Title: _____

Phone: _____ Email: _____

(*Continues*)

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Financial Institution Routing Number: _____

Type of Account at Financial Institution:

- ☐ Checking
- ☐ Savings
- ☐ Other, please explain: _____

Account Number with Financial Institution: _____

Account Number Linkage to Provider Identifier:

- ☐ NPI
- ☐ TIN

EFT Request Submission Type:

- ☐ New Enrollment
- ☐ Enrollment Cancellation
- ☐ Enrollment Change (*please provide at least 30 days' notice to avoid EFT service interruption*)

Required Documentation to be submitted with this completed form:

- ☐ Voided Check

  or

- ☐ Letter from your Financial Institution (on their letterhead) that includes: their Routing Number; your Account Number; and any other information required to identify your account.

AUTHORIZED ANCILLARY FACILITY REPRESENTATIVE

By signing and dating below, I, the appropriate designated representative of the Ancillary Facility noted here, attest that the information provided is accurate and complete.

Name: _____ Title: _____

Signature: _____ Date: _____