

EL PASO FIRST

Health Plans, inc.

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH CREDITS)

Provider/Group Name: _____

NPI Number: _____

Tax-ID Number: _____

I (we) hereby authorize:

El Paso First Health Plans, Inc. hereinafter called El Paso First, to initiate credit entries to my (Our) Checking Account/ Savings Account (select one) indicated below at the depository financial institution named below, hereafter-called DEPOSITORY, and to credit the same to such account. I (we) acknowledge that the origination of ACH transaction to my (our) account must comply with the provisions of U.S. law.

Depository Name: _____

Branch: _____

City: _____

State: _____ Zip: _____

Account Number: _____

Routing Number: _____

This authorization is to remain in full force and effect until the El Paso First has received written notification from me (or either of us) of its termination in such time and in such manner as to afford El Paso First and DEPOSITORY as reasonable opportunity to act on it.

Name(s): _____

Title: _____

Date: _____

Signature: _____

NOTE: CREDIT AUTHORIZATIONS MUST PROVIDE THAT THE RECEIVER MAY REVOKE THE AUTHORIZATION ONLY BY NOTIFYING THE ORIGINATOR IN THE MANNER SPECIFIED IN THE AUTHORIZATION.

ATTACH VOIDED CHECK