EFT/ACH REQUEST FORM

General Information: ☐ NEW Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

Requested Effective Date: ______________________________

Provider Name: ______________________________

Provider Contact Name: ______________________________

Provider Address: ______________________________

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**

Form Completed By: ____________________ Date: ____________

(1) 30 days is needed to process a request.
(2) Please attach a copy of a voided check and a W9
(3) Email to: VIVIDAEFT@ILSHEALTH.COM or Fax to: (631)963-4935
(4) Mail to:
Vivida Health
Attention: Finance
PO Box 211290
Eagan, MN 55121

For Internal Use Only

PayID: _______ _______ _______ _______ _______ _______ _______ _______ _______ _______