

Attachment to Provider Notice

**Directed Payment Data Collection Form**

Facility Name:		
Facility Tax ID:		
System Affiliated With:		
Contact Name for Directed Payments:		
Contact Phone for Directed Payments:		
Contact Email for Directed Payments:		
<b>Preferred Payment Method:</b> (EFT or Check)		
	<b>EFT Information:</b> Please note that the health plan may require a letter from your banking institution on the bank's letterhead to avoid payment errors.	
Bank Name:		
Account #		
Routing #		
<b>Check Information:</b>		
Address:		
Pay to Name:		
Attention of:		