



HOLISTA

Empowering Value-Based Healthcare

Electronic Funds Transfer (EFT) Authorization Agreement

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Get your reimbursement faster and easier with EFT! To receive your payments by EFT, please complete this form and **return it with a scanned or faxed copy of a voided check.** (This Authorization Agreement will not be valid without a voided check.)

Submission Options		
Send this completed form and voided check to Holista via:		Fax: 866-231-6344 or Email: providerservices@holistahealth.com
Submission Reason		
Select one checkbox.	<input type="checkbox"/> New EFT Authorization <input type="checkbox"/> Account or bank change to existing EFT Authorization	
Provider Information		
Provider Name (Include d/b/a, if any.)	Taxpayer Identification Number	Select one checkbox. <input type="checkbox"/> SSN <input type="checkbox"/> EIN
Street Address		
City	State	Zip Code
Phone Number	Email Address	
Financial Institution Information		
Financial Institution Name	Financial Institution Routing Number (Include 9 digits with any leading zeros.)	
Account Number (Include up to 10 digits with any leading zeros.)	To indicate account type, select one checkbox. <input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account	
<p>Note: Please return this form with a voided check or the Authorization Agreement will not be valid.</p>		
Authorization		
<p>I agree to receive all vendor payments from Holista, LLC by electronic funds transfer according to the terms of the EFT program. I agree to return to Holista, LLC any EFT payment incorrectly disbursed by Holista, LLC. I agree to hold harmless Holista, LLC and its agencies and departments for any delays or errors caused by inaccurate or outdated registration information or by the financial institution listed above.</p>		
Printed Name	Title	
Authorized Signature	Date	

CONFIDENTIALITY NOTICE:

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