HOLISTA
Empowering Value-Based Healthcare

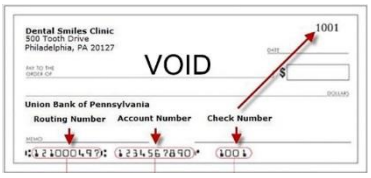
Electronic Funds Transfer (EFT) Authorization Agreement

Phone: (888) 560-6855
Fax: (866) 231-6344
E-mail: providerservices@holistahealth.com
Web Portal: atapwp.therapyadmin.com

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.	❑ New EFT Authorization | ❑ Account or bank change to existing EFT Authorization

Provider Information		
Provider Name *(Include d/b/a, if any.)*	Taxpayer Identification Number	*Select one checkbox.* ❑ SSN | ❑ 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.* ❑ Checking Account | ❑ Savings Account
Note: Please return this form with a *voided check* or the Authorization Agreement will not be valid.	

Authorization	
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I agree to hold harmless Holista, LLC and its agencies and departments for any delays or errors caused by inaccurate or outdated registration information or by the financial institution listed above.	
Printed Name	Title
Authorized Signature	Date