Electronic Funds Transfer (EFT) Authorization Agreement

This document is intended to establish Electronic Funds Transfer (EFT) enrollment. This document shall become effective when submitted by the provider. The responsibilities and obligations contained in this document will remain in effect as long as claims are submitted to WPS. Either party may terminate this arrangement by giving the other party thirty (30) days written notice of its intent to terminate. In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.

DEG1: Provider Information

Provider Name:

Doing Business As Name (DBA):

Provider Address

Street: City: State/Province:

Zip Code/Postal Code: Country Code:

DEG2: Provider Identifiers Information

Provider Identifiers

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):

National Provider Identifier (NPI):

Other Identifier(s)

Assigning Authority: Trading Partner ID:

Provider License Number: License Issuer:

Provider Type: Provider Taxonomy Code:

DEG3: Provider Contact Information

Provider Contact Name:

Title:

Telephone Number: Telephone Number Extension:

Email Address: Fax Number:

DEG4: Provider Agent Information

Provider Agent Name:

Agent Address

Street: City: State/Province:

Zip Code/Postal Code: Country Code:

Provider Agent Contact Name: Title:

Telephone Number: Telephone Number Extension:

Email Address: Fax Number:

DEG5: Federal Agency Information

Federal Program Agency Name:

Federal Program Agency Identifier:

Federal Agency Location Code:

DEG6: Retail Pharmacy Information

Pharmacy Name:

Chain Number:

Parent Organization ID:

Payment Center ID:

NCPDP Provider ID Number:

Medicaid Provider Number:

DEG7: Financial Institution Information

Financial Institution Name:

Financial Institution Address:

Street: City:

State/Province: Zip Code/Postal Code:

Financial Institution Telephone Number: Telephone Number Extention:

Financial Institution Routing Number:

Type of Account at Financial Institution:

Provider's Account Number with Financial Institution:

Account Number Linkage to Provider Identifier

Provider Tax Identification Number (TIN):

National Provider Identifier (NPI):

DEG8: Submission Information

Reason for Submission: ◯ New Enrollment ◯ Change Enrollment ◯ Cancel Enrollment

Include with Enrollment Submission: ◯ Voided Check ◯ Bank Letter

Authorized Signature

Printed Name of Person Submitting Enrollment:

Submission Date: Requested EFT Start/Change/Cancel Date:

In order to determine the status of this enrollment, please contact the EDI department by phone or email using the following information:

WPS Health Insurance
ARISE Health Plan
EPIC

Wisconsin Physicians Service
Electronic Data Services
P.O. Box 8128
1717 West Broadway
Madison, WI 53713

Fax: (608) 223-3824
Phone: (800) 782-2680
Email: edi@wpsic.com

Tricare for Life

Wisconsin Physicians Service
Electronic Data Services
P.O. Box 8128
1717 West Broadway
Madison, WI 53713

Fax: (608) 223-3824
Phone: (800) 782-2680
Email: edi@wpsic.com

Veterans Administration – VA
VAPCCC Region 3, VAPCCC Region 5A,
VAPCCC Region 5B and VAPCCC Region 6

Wisconsin Physicians Service
Electronic Data Services
P.O. Box 8128
1717 West Broadway
Madison, WI 53713

Fax: (608) 223-3824
Phone: (800) 782-2680
Email: edi@wpsic.com

For further updates visit our website at: http://www.wpsic.com/edi/tools.shtml