



Authorization Agreement

For Electronic Fund Transfers (EFTs)

Thank you for your interest in Electronic Funds Transfer (EFT) Funds for your Claim Payments. Once this process begins, claims payment will be electronically deposited into your checking account weekly. This will include a tracing number that will tie back to your Remittance Advice. The information contained within this form will be applied to all applicable contracts with Quartz Health Solutions, Inc., Quartz Health Benefit Plans Corporation, Quartz Health Plan Corporation, Quartz Health Plan MN Corporation and Quartz Health Insurance Corporation.

Step 1: Please complete the EFT authorized agreement form. If signing up or changing information, complete the EFT authorization in its entirety. If you want to cancel the EFT process, complete sections 1 and 4.

Return the agreement form to Quartz at:

Quartz
Attn: Provider Services Dept.
840 Carolina Street
Sauk City, WI 53583

Or fax to: (608) 643-5230
Attn: Provider Services Dept.
If you have any questions on this form, please contact your Provider Relations Coordinator.

Step 2: The normal enrollment process takes 7-10 business days. As part of this enrollment process, Quartz will transfer \$.01 to your account as a test run. Quartz will contact your EFT provider to verify the money was received. At this time, the enrollment process is complete, your next claims payment would pay via EFT.

If you would like to know the status of your EFT enrollment or have a question regarding an EFT transaction, call the Finance Department at (608) 471-4902.

Step 3: To receive the tracing number to tie back to your Remittance Advice, after enrollment has been confirmed, you **must** contact your financial institution to arrange for the delivery of the CORE- required Minimum CCD+ data elements.

* Indicates a required field.

Implementation Information

Section 1: Provider Information

Provider Name: *				
Physical Address: *				
City: *		State / Province: *		Zip: *
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) : *				
National Provider Identifier: * (Provider may list multiple NPI Numbers if they share the Federal Tax ID Listed above. A separate Implementation Form needs to be completed for each unique Federal Tax ID)				



Section 2: Provider Contact Information			
Provider Contact Name: *			
Title:*		Phone:*	
Email:*		Fax:*	

Section 3: Financial Institution Information:				
Financial Institution Name: *				
Street Address:*				
City:*		State / Province: *		Zip: *
Financial Institution Phone Number:*				
Financial Institution Routing Number:*				
Type of Account at Financial Institution (i.e. Checking, Savings):*				
Provider's Account Number with Financial Institution:*				
Account Number Linkage to Provider Identifier: *(select one)				
<input type="checkbox"/>	Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)			
<input type="checkbox"/>	National Provider Identifier (NPI)			

Section 4: Submission Information			
Reason for Submission: (Check one):	<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Change Enrollment	<input type="checkbox"/> Cancel Enrollment

Authorized Signature:*	
Written Signature of Individual Submitting Enrollment:*	
<i>This signature authorizes the provider to enroll with EFT with Quartz Health Solutions, Inc., Quartz Health Benefit Plans Corporation, Quartz Health Plan Corporation, Quartz Health Plan MN Corporation, and Quartz Health Insurance Corporation.</i>	
Printed Name of Person Submitting:*	
Printed Title of Person Submitting Enrollment:*	
Submission Date (e.g. CCYYMMDD):*	

Form Help and Definitions

Provider Contact Information:

Provider Contact Name: Name of a person in provider's office that handles EFT (Electronic Fund Transfers)

Title: Title associated with Contact

Telephone Number: Telephone Number associated with Contact

Email Address: Email Address associated with Contact

Fax Number: Fax Number associated with Contact

Financial Institution Information:

Financial Institution Name: Official name of the provider's financial institution

Street Address: The street address associated with receiving depository financial institution

City: The city associated with receiving depository financial institution

State / Province: The State / Province associated with receiving depository financial institution

Zip Code: The Zip Code associated with receiving depository financial institution

Financial Institution Telephone Number: A contact phone number at the provider's bank

Financial Institution Routing Number (ABA): A 9-digit identifier of the financial institution where the provider maintains an account to which the payments are to be deposited.

Type of Account at Financial Institution: i.e. Checking, Savings, etc.

Provider's Account Number with Financial Institution: Provider's account number at the financial institution to which EFT payments are to be deposited.

Account Number Linkage to Provider Identifier: Provider preference for grouping (bulking) claim payments – must match preference for v5010 X12 835 remittance advice

Submission Information: Select either: New Enrollment, Change Enrollment or Cancel Enrollment

Authorized Signature:

Written Signature of Person Submitting Enrollment: The signature of an individual authorized by the provider to initiate, modify, or terminate an enrollment.

Printed Name of Person Submitting: The printed name of the person signing the form

Printed Title of Person Submitting Enrollment: The title of the person signing the form