

**Electronic Funds Transfer Authorization Form**  
(available to in-network providers only)

New       Change (please describe): \_\_\_\_\_

Company Name: \_\_\_\_\_

Contact Name & Phone: \_\_\_\_\_

Federal ID Number: \_\_\_\_\_

ConnectiCare Provider or Group ID Number: \_\_\_\_\_

**Account Information**

Bank or Credit Union Institution: \_\_\_\_\_

Bank Telephone No.: \_\_\_\_\_

Branch: \_\_\_\_\_

Acct. Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Acct. No.: \_\_\_\_\_ Transit Routing No.: \_\_\_\_\_

*I authorize ConnectiCare to remit payment via electronic transfer to the bank account listed above. In addition, I understand that by signing this form I will not receive a paper Explanation of Payment (EOP) with each payment, but will have access to EOP statements via Provider Connections, ConnectiCare's online provider tool.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Note: You must notify ConnectiCare's Financial Operations Department at least 10 business days prior to changing or canceling your bank information. For information on Electronic Remittance Advice (ERA), contact your claims clearinghouse.*

Fax/Mail to:                      Finance Department  
  Attn: Ewelina Gradka  
  ConnectiCare, Inc.  
  175 Scott Swamp Road  
  Farmington, CT 06032-3124  
  fax (860) 674-2215

**Internal Use Only**

Form Received: \_\_\_\_\_ EFT Effective Date: \_\_\_\_\_