RightCare
SCOTT & WHITE HEALTH PLAN
Now part of Baylor Scott & White Health

Electronic Funds Transfer (EFT) Authorization Agreement

Provider Name	Doing Business As (DBA)
Provider Street Address	**Provider City**
Provider State/Province	**Provider ZIP Code/Postal Code**
Provider Tax Identifier (TIN) or Employer Identifier (EIN)	**National Provider Identifier (NPI)**
Assigning Authority	**Trading Partner ID**
Medicaid	
Provider Contact Name	**Provider E-Mail Address**
Provider Phone Number	**Provider Fax Number**
Financial Institution Name	**Financial Institution Street Address**
Financial Institution Telephone Number	**Financial Institution City/State/Zip**
Financial Institution Routing Number	**Type of Account at Financial Institution**
Provider's Account Number at Financial Institution	**Provider Preference for Grouping Claim Payments**
	____ TIN or ____ NPI (Please select one.)
Reason for Submission	
___ NEW ___ CHANGE ___ CANCEL (Please select one.)	

I (we) hereby authorize Right*Care* from Scott & White Health Plan (Right*Care)* to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I am (we are) responsible for the validity of the information on this form. If Right*Care* erroneously deposits funds into my (our) account, I (we) authorize Right*Care* to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay cycle.

I (we) agree to comply with all certification and credentialing requirements of Right*Care* and the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by Right*Care* or its authorized affiliate(s) or subcontractor(s). I (we) understand that payment of claims will be made from federal and state funds, and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

I (we) will continue to maintain the confidentiality of records and other information relating to clients covered by programs offered through Right*Care* in accordance with applicable state and federal laws, rules, and regulations.

_____ _____

Authorizing Signature Date Signed

_____ _____

Printed Name Title of Signatory

For the convenience of having direct deposit, you must be willing to download your EOB/EOP directly from the https://rightcare.valencehealth.com/Login.aspx?ReturnUrl=%2fdefault.aspx website. *No paper copies will be mailed.

RETURN THIS FORM TO:

Right*Care* from Scott & White Health Plan
ATTN: EFT Enrollment Department
1206 West Campus Drive, Temple, Texas 76502
*Forms must be mailed back to the address listed above. Faxed copies are NOT accepted due to readability.

TEXAS STAR PROGRAM
Your Health Plan ■ Your Choice