Electronic Funds Transfer (EFT) Authorization Agreement

Please complete this form to receive electronic payments

Please type directly into this form or print clearly. Please complete all required information.

Provider Information (required)			
Provider Name			
Street Address	City	State	ZIP

Provider Identifiers Information (required)	
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	National Provider Identifier (NPI)

Provider Contact Information (required)		
Provider Contact Name	Telephone Number	Telephone Number Extension
Email Address		

Authorization Agreement for Automatic Deposits (Automated Clearing House Credits)
I, provider name ("PROVIDER"), hereby authorize eClusive, LLC ("COMPANY") to initiate credit entries and, if necessary, debit entries and adjustments for any credit entries in error to PROVIDER's checking/savings account(s) indicated below and the bank named below ("BANK"), to credit and/or debit the same account.

Financial Institution Information (required)			
Please provide PROVIDER's bank account information below.			
Financial Institution Name			
Street Address	City	State	ZIP

Financial Institution Routing Number	Type of Account at Financial Institution ☐ Checking ☐ Savings
Provider's Account Number With Financial Institution	Account Number Linkage to Provider Indentifier ☐ Provider Tax Identification Number (TIN)

Submission Information (required)

Reason for Submission
☐ New Enrollment ☐ Change Enrollment

Authorized Signature (required)

The undersigned hereby certifies that the information provided herein is true and accurate and that he/she has been authorized by PROVIDER to execute this agreement on behalf of PROVIDER to form a legally binding contract, and understands that acceptance of this Agreement constitutes an agreement to be bound to perform in strict conformity with all contracts between PROVIDER and COMPANY, and all applicable laws and regulations.

This Authorization remains in full force and effect until COMPANY has received written notification from PROVIDER's duly authorized representative(s) of PROVIDER's termination. Such notification shall be provided in writing and in enough time to provide the COMPANY a reasonable opportunity to operationally and otherwise conclude activities related to the termination.

Signature of person submitting enrollment	Printed name of person submitting enrollment
Printed title of person submitting enrollment	Submission date

Please email this form and a voided check or bank letter to intake@eclusive.com