INSTAMED NETWORK FUNDING AGREEMENT
(Payer Payments)

This **NETWORK FUNDING AGREEMENT** will become effective upon execution by "Customer" and incorporates all the terms and conditions of the Terms of Service agreement and/or Transaction Services Agreement between Customer and InstaMed (including all appendices, schedules, exhibits and attachments, the "Agreement"). This Network Funding Agreement will be attached as Appendix IV and incorporated in the Terms of Service agreement and/or as Schedule C in the Transaction Services Agreement.

NOTE: By enrolling in Payer Payments, you agree that you will NO LONGER receive a paper check or paper explanation of payment (EOP). These are available on the Provider Portal.

Please complete the form below, sign and send to InstaMed:

- **Fax: (877) 755-3392**
- **Mail: P.O Box 58790 Philadelphia, PA 19102**

If you have any questions, please contact InstaMed at (866) 945-7990.

SECTION ONE – GENERAL INFORMATION

Provider Information (*all information is required unless otherwise noted*)

Tax ID	**Practice Administrator Contact Information**
Provider Name (*an individual*)	Name
Practice Name (*a business entity*)	Phone
Address	Email
City State Zip	Fax

SECTION TWO – NPI

NPIs

Please give your Billing Provider NPI(s) for the Provider Name above and, if populated, Practice Name. If your Practice uses Service Provider NPI(s) for claims billing, please list them also. If your Practice does not use Service Provider NPI(s) for claims billing, you do not need to list them.

Billing Provider NPI (*Practice NPI*): _____ Billing Provider NPI (*Practice NPI*): _____

Service Provider NPI: _____ Service Provider NPI: _____

SECTION THREE – REMITTANCE FILE FORMAT AND DELIVERY

Please select desired remittance file format:

☐ 4010 (004010X091) ☐ 5010 (005010X221)

All electronic remittance advice (ERAs) are automatically delivered through the InstaMed Online portal. Please select any additional options for ERA delivery:

☐ Receive ERA via secure file transfer protocol (SFTP)
☐ Receive ERA through existing clearinghouse

Clearinghouse Name: _____

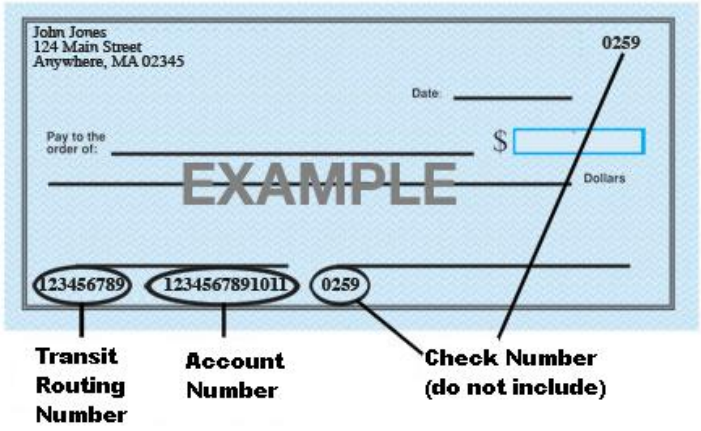
SECTION FOUR – ELECTRONIC FUNDS TRANSFER

Please complete the form below and attach a voided check or photocopy of a voided check. One form is required per bank account.

Bank Account Information

Bank Name	Bank Street Address
Transit Routing Number (TRN) (*see graphic below*)	City State Zip
Account Number (*see graphic below*)	Account Type: ☐ Savings ☐ Checking

ATTACH VOIDED CHECK HERE OR ATTACH A PHOTOCOPY OR BANK LETTER ON A SEPARATE PAGE



Authorization

The undersigned authorizes InstaMed Communications, LLC D.B.A InstaMed to make electronic debits, payments and other entries to the bank account at the depository financial institution (depository) named above for services performed under the Agreement between the organization identified above and InstaMed and its affiliates. Such entries shall be made through the regional automated clearinghouse (ACH) associations, subject to the Rules. This authorization is to remain in full force and effect until InstaMed has received written notice of its termination, allowing InstaMed reasonable opportunity to act on it, but in no event later than thirty (30) days advance notice. Revocation will not apply to transactions initiated before the effective date of such revocation. If you do not terminate this authorization after such notice, you authorize InstaMed to deduct such fees from the transfers of funds owed to you under the network participation agreement to the depository specified above. InstaMed may cease providing any or all of these services upon notice to Customer. The undersigned certifies that the above information is true and accurate in all respects and that the undersigned has the authority to initiate the actions requested herein and will promptly notify InstaMed of any changes to the information on this form in writing.

SECTION FIVE – AUTHORIZATION

Authorized Signature

By: _____ Date: _____

Print Name: _____ Print Title: _____

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