Bank Account Update Form
Healthcare Provider

INSTRUCTIONS: This form should only be used if you have an existing EFT/ERA enrollment with ECHO Health, Inc. and would like to change the bank account set up to receive ACH payments.

1. This is a fillable form. Type in your information on your screen and print the form, *OR* print the form and fill in your information. **Note**: ***** Required information; ****** Required information for one section *OR* the other in which it appears.
2. Manually sign the form. Return the completed form to ECHO Health, Inc. by email *(secure recommended)*, fax or regular mail.

Email to: edi@EchoHealthinc.com
Fax to: 440.835.5656

Mail to: ECHO Health, Inc.
810 Sharon Drive
Westlake, OH 44145

HEALTHCARE SERVICE PROVIDER INFORMATION

Name* _____

Billing Address *(number, street)** _____

(city, state, zip code)* _____

Tax ID Number *(TIN)** _____   **Email*** _____

SECURITY

For security purposes, please provide an **ECHO® Draft Number** and matching **ECHO Draft Amount** to validate against your Tax ID. The ECHO Draft Number is a 9-digit number starting with "2" or a 10-digit number starting with "1".

ECHO Draft Number* _____   **ECHO Draft Amount* $** _____

AUTHORIZATION TERMS & CONDITIONS

Healthcare Service Provider hereby authorizes ECHO Health, Inc., hereinafter called "ECHO", to initiate credit entries for approved benefit plan payments to said Healthcare Service Provider's account, identified hereinafter as "Depository".

I also understand that this authority is to remain in full force and effect until ECHO has received written notification from Healthcare Service Provider of its termination in such time and in such manner as to afford ECHO a reasonable opportunity to act on it, which in any way shall not be less than ten banking days after receipt.

Bank Account to be Updated (Depository) Information
Required: Enter information for the existing account you wish to replace.

BANK NAME** _____

ADDRESS** _____
(number & street)

_____
(city, state, zip code)

TRANSIT/ABA NO.** _____

ACCOUNT NO.** _____

New BANK ACCOUNT (Depository) Information
Required: Enter information for the new account you wish to set up.

BANK NAME** _____

ADDRESS** _____
(number & street)

_____
(city, state, zip code)

TRANSIT/ABA NO.** _____

ACCOUNT NO.** _____

ACCOUNT TYPE** _____
(checking or savings)

APPROVAL *(By person holding Tax ID shown on this form – please fill in all information completely).*

Executed By *(print name)** _____   **Title*** _____

Phone* _____   **Email*** _____

Date* _____   **Executed By** *(signature)** _____
(mm/dd/yyyy)

ECHO Health, Inc. ‖ **810 Sharon Drive** ‖ **Westlake, Ohio 44145** ‖ **ph: 440.835.3511** ‖ **fax: 440.835.5656** ‖ **www.EchoHealthinc.com**

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