AUTO PAY

PROVIDER 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)**
Provider Contact Name	**Provider Email Address**
Provider Phone Number	**Provider Fax Number**
Financial Institution Name	**Financial Institution Street Address**
Financial Institution Telephone Number	**Financial Institution City/State/Zip Code**
Financial Institution Routing Number	**Type of Account at Financial Institution**
Provider's Account Number at Financial Institution	**Provider Preference for Grouping Claim Payments**
	Check one: ☐TIN ☐NPI

Reason for Submission			
Check one:	☐NEW	☐CHANGE	☐CANCEL

I (we) hereby authorize Alliant Health Plans 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 Alliant Health Plans erroneously deposits funds into my (our) account, I (we) authorize Alliant Health Plans 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 Alliant Health Plans and the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by Alliant Health Plans or its authorized affiliate(s) or subcontractor(s). I (we) will continue to maintain the confidentiality of records and other information relating to clients covered by programs offered through Alliant Health Plans in accordance with applicable state and federal laws, rules, and regulations.

Authorizing Signature _____ Date Signed _____

Printed Name _____ Title of Person Signing _____

For the convenience of having direct deposit, you must be willing to download your EOB/EOP directly from www.alliantplans.com. ***No paper copies will be mailed.***

PLEASE RETURN THIS FORM ELECTRONICALLY or MAIL TO:

Alliant Health Plans | providerrelations@alliantplans.com | 1503 North Tibbs Road | Dalton, GA 30720

**** Forms must be mailed in or scanned and sent by email. Fax copies WILL NOT be accepted due to readability.***