



EFT/ACH REQUEST FORM

General Information: NEW Enrollment Change Enrollment Cancel Enrollment

Requested Effective Date: _____

Provider Name: _____

Provider Contact Name: _____

Provider Address: _____

Contact Phone #: _____

Contact Email: _____

Tax ID Number: _____

All applicable Billing/Pay to NPI: _____

Bank Information:

ACH Routing Number (ABA#): _____

Bank Account Number: _____

Bank Name: _____

Bank Address: _____

Check one Savings Checking

Form Completed By: _____ Date: _____

- (1) Please attach a copy of a voided check and a W9
- (2) Email to: EFT@ILSHEALTH.COM or Fax to: (631)963-4935

For Internal Use Only

PayID: _____