Independent Clinics
OF WASHINGTON

Electronic Remittance Advice (ERA) Enrollment

Authorization for ACH Payments

ICW is reducing the use of paper checks and paper explanation of payments (EOPs) as part of our ongoing efforts to go paperless. Electronic payments will be made via ACH and EOP's will be sent securely to the designated email address.

To ensure future payments are uninterrupted, submit this completed enrollment form by email (claims@ic-wa.org) or fax (206-834-6000).

AUTHORIZATION FOR ACH PAYMENTS

Provider Group Name: _____

Tax ID: _____

Group NPIs: *(Attach additional sheet if necessary)*

1. _____
2. _____
3. _____

Contact Name: _____

Contact Telephone #: _____

EOP E-Mail: _____

BANK INFORMATION

*I am **reporting a change** to the banking details. Complete the section below.*

Type or Account: ☐ Checking ☐ Savings

Bank Name	**Account Number**	**Routing Number**

Address	**City**	**State, Zip**

I hereby authorize Independent Clinics of Washington (ICW) to deposit payments due to the entity identified above to the bank account listed. It is understood and agreed that this authorization will remain in effect until receipt by ICW of written instructions to cancel. It is further understood that ICW is under no obligation to submit payment electronically and that the contact listed above will be notified when electronic payments commence.

Print Name	**Signature**	**Date**