Electronic Funds Transfer (EFT)

Enrollment Form

SANFORD HEALTH PLAN

Reason for Submission: ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

Submission Date: ___/____/_____

Financial Institution Information

Financial Institution Name: _____

Financial Institution Address: _____

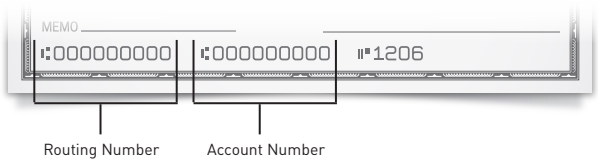
City: _____ State: _____ Zip: _____

Type of Account (ex. Checking, Savings): _____

Routing Number: _____

Account Number: _____

PLEASE ATTACH VOIDED CHECK FOR VERIFICATION.



Provider Information:

Provider/Legal business name: _____

Provider address: _____

City: _____ State: _____ Zip: _____

Please provider your NPI, and TIN or EIN)

National Provider Identifier (NPI): | | | | | | | | | | |

Provider Federal Tax Identification Number (TIN): | | | | | | | | | |

OR

Employer Identification Number (EIN): | | | | | | | | | |

Contact Information:

Contact Name: _____

Title: _____

Phone: _____ Ext: _____ Fax: _____

Email: _____

Covered Entity Attestation (Required):

☐ No, I am not a covered entity

☐ Yes, Provider is a covered entity

Identity of Parties

Sanford Health Plan is the issuing agency for this Agreement. It will be referred as "Sanford Health Plan" in this Agreement. Sanford Health Plan EDI Department is referred as "EDI Operations". Sanford Health Plan's address is: 300 Cherapa Place Suite 201, Sioux Falls, SD 57103.

Duration of Agreement

This Agreement is effective on the date of signature by Sanford Health Plan and will remain in effect unless a written notice from either party is issued wishing to terminate the Agreement. This Agreement may be modified at any time upon mutual consent of the parties.

Privacy

Sanford Health Plan shall comply with the security of medical data provisions of the Health Insurance Portability and Accountability Act of 1996 and the accompanying regulations. Sanford Health Plan shall comply with the privacy of medical data provision of the Health Insurance Portability and Accountability Act of 1996, including the use of standard transactions in any electronic transactions performed.

By the signature below, the Enrollment Form hereby represents and warrants that they are a "Covered Entity" and in compliance with applicable provisions of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH") (enacted as part of the American Recovery and Reinvestment Act of 2009) and the Affordable Care Act ("ACA") (Public Law Nos. 111-148 and 111-152, enacted in March 2010) and the standards, operating rules, and related regulations and guidance promulgated thereunder (referred to collectively, hereinafter, as "the HIPAA requirements"), as may be amended from time to time.

The undersigned representative of the Enrollment Form affirms that he or she is duly empowered to represent the Provider for purposes of this attestation and has knowledge confirming the accuracy of this attestation.

Authorized Representative Signature completing form:

_____ _____

Signature Date signed

Authorized Representative Print Name: _____

Allow 4 weeks for completion of the enrollment process. If after four weeks you do not start receiving EFT payments, please contact Provider Relations at 1-800-601-5086. This agreement is to remain in full force and effect until Sanford Health Plan has received notification of its termination in such time and in such manner as to afford Sanford Health Plan and the depository a reasonable time to act.

Please fax or mail this form, along with other documentation, to:

Sanford Health Plan
Attention: Provider Relations
PO Box 91110 Sioux Falls,SD 57109-1110
Fax: (605) 328-7224