curative

NOTE: Complete all sections below and attach a voided check or a signed letter from your bank on bank letterhead along with a current W9.

Type of authorization: ☐ **New** ☐ **Change**	
Provider name:	**Billing TPI or Tax ID/EIN: (9-digit)**
National Provider Identifier (NPI)/Atypical Provider Identifier (API):	**Group NPI (if applicable):**
Provider accounting address:	**Provider number:**
Bank name:	**Bank phone number:**
ABA/Transit number:	**Account number:**
Bank address:	**Account type:** *(Check one)*
	☐ **Checking** ☐ **Savings**

I (we) hereby authorize Curative Health Plan 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 (we) am responsible for the validity of the information on this form. If the company erroneously deposits funds into my (our) account, I (we) authorize the company to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay period.
I (we) will continue to maintain the confidentiality of records and other information relating to clients in accordance with applicable state and federal laws, rules, and regulations.

Authorized signature:	**Date:**
Title:	**E-mail address: (if applicable)**
Contact name:	**Contact phone number:**

Please return this form to:
Curative Health Plan
PO BOX 1786
Austin, TX 78767

Fax number:
866-813-7747
Email address:
providerrelations@curative.com