



University of Utah Health Plans Electronic Funds Transfer (EFT) Request Form

VENDOR INFORMATION

Vendor Name: _____ A/P Vendor Number: _____

CONTACT

Name: _____ Phone Number: _____

E-mail: _____

BANK INFORMATION

Bank Name: _____ Bank Phone Number: _____

Bank ABA (Routing) Number _____ Bank Account Number: _____

This EFT request form authorizes University of Utah Health Plans to deposit funds for claims payment directly into a vendor's bank account. This request form also allows for reversal of payments that were made in error. This authority is to remain in full force and effect until University of Utah Health Plans has received written notification from the vendor of its termination in such time and manner as to afford University of Utah Health Plans a reasonable opportunity to act on it.

SIGNATURES

_____ Printed Name	_____ Printed Name	_____ Printed Name
_____ Vendor Title	_____ Vendor Title	_____ Vendor Title
_____ Date	_____ Date	_____ Date

Please fax to: EDI Coordinator,, University of Utah Health Plans, 801-587-6433