Moda Health PPO, Moda Health PPORX (PPO), and Moda Health HMO (HMO-POS)

PAYMENT BY EFT FORM

Authorization agreement for monthly Electronic Funds Transfer (EFT) from checking account using Automated Clearing House (ACH)

Instructions:

1.)*Complete, sign and date this Authorization Agreement for monthly automatic bank deduction of your insurance premiums.*

2.)*Attach a blank VOID check from the checking account you wish to make this monthly draft.*

3.)*Return this form and the attached voided check to Moda in the enclosed return envelope.*

Subscriber name: _____
(Last) (First) (MI)

Subscriber ID#: _____

(As shown on your Moda Health PPO, Moda Health PPORX, or Moda Health HMO (HMO-POS) identification card)

I authorize Moda Health to charge my checking account for the monthly insurance premiums for the above named individual. I also authorize my bank to honor these monthly charges. This authority will remain in full effect until Moda Health and my bank have received written notification from me of its termination in such time and in such manner as to afford my bank and Moda Health a reasonable opportunity to act upon it. I have the right to stop payment of a debit entry by notification to my bank in such time as to afford my bank a right to have the amount of an erroneous debit immediately credited to my account by my bank, provided I send written notice of such an error to the bank within 15 days following issuance of

the account statement or 45 days after posting whichever occurs first. I also understand it may take up to one month after the policy effective date to begin electronic deductions and that the deduction amount will be for the balance due or a premium notice will be sent so my health insurance may be kept current. If you have any questions about the form or the EFT process, please contact Moda Member Services at 503-265-4762 or toll free 1- 877-299-9062, between the hours of 7 a.m. and 8 p.m. Pacific Time, seven days a week. TTY users should call 711.

Subscriber signature:_____ Date: _____

If the holder of the checking account is different from the Subscriber for the insurance, please also provide the account holder's signature below.

Account holder signature:_____ Date: _____

ATTACH VOIDED CHECK HERE

Return to: **Moda Health**

Billing and Eligibility Medicare Enrollment

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