835 ENROLLMENT REQUEST
EMPIRE HEALTHCARE IPA (EHI01)

Email this completed form to edisupport@allcaretoyou.com. Please make sure to print legibly and to complete this form in its entirety. You risk delaying enrollment if the application is unreadable or incomplete.

PROVIDER INFORMATION:

Provider Name:

Provider Address:

PROVIDER IDENTIFIER INFORMATION:

Provider Federal Tax Identification Number (TIN) OR Employer Identification Number (EIN):

National Provider Identifier (NPI):

PROVIDER CONTACT INFORMATION:

Provider Contact Name:

Telephone Number:

Fax Number:

Email Address:

ELECTRONIC REMITTANCE ADVICE INFORMATION:

Preference for Aggregation Of Remittance Data:

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Note: *Account Number Linkage to Provider Identifier. Must match preference for EFT payments.*

SUBMISSION INFORMATION:

Reason for Submission: New ERA Enrollment

Authorized Signature:

Note: *Electronic Signature (typed name) of Person Submitting ERA Enrollment.*

EMPIRE HEALTHCARE
INDEPENDENT PHYSICIANS ASSOCIATION

Empire Healthcare
C/O All Care To You
PO Box 4367
Orange CA 92863

AUTHORIZATION FOR ACH DEPOSIT OF VENDOR PAYMENT

Payee/Vendor Name _____

Address _____

City, State Zip _____

Telephone _____

Contact Name _____

Contact e-mail _____
(for ACH remittance notification)

Complete this section for **new enrollments** or for **financial institution or account changes.**

Select one: ____New Enrollment ____Financial Institution or Account Change

Bank Name _____

Branch (if applicable) _____

City, State Zip _____

Transit/Routing Number ____ ____ ____ ____ ____ ____ ____ ____ ____

Bank Account Number _____

Account Type (check one) ____Checking Account ____Savings Account

I, the undersigned, authorize Empire Healthcare to deposit payments directly to the account indicated above and to correct any errors which may occur from the transactions. I also authorize the financial institution named above to post these transactions to that account. This authorization will remain in force until Empire Healthcare receives written notice of cancellation from me. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

Signature _____ Date_____

Name (printed)_____ Title_____

Complete this section to **CANCEL** your ACH electronic deposit authorization.

I, the undersigned, hereby cancel the authorization for Empire Healthcare to originate ACH electronic deposit entries into my checking/savings account. This cancellation is effective as soon as Empire Healthcare has reasonable time to act upon it.

Signature _____ Date _____

Name (printed) _____ Title _____

Mail the completed form to the address above, fax to (949)396-2614 or email to MikeSayed@AllCareToYou.com

For EHI Use Only

Vendor Number _____ Date Received _____