835 ENROLLMENT REQUEST
(Silicon Valley Medical Development - SVMD)

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: ☐ ☐

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

SUBMISSION INFORMATION:

Reason for Submission: New ERA Enrollment

Submit by Email

Authorized Signature:

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

Silicon Valley Medical Development

Silicon Valley Medical
Development C/O
All Care To You
P.O. 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.**

Enroll in electronic Remittance Advice: __ Yes ___ No

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 the Silicon Valley Medical Development 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 SVMD 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 the Silicon Valley Medical Development to originate ACH electronic deposit entries into my checking/savings account. This cancellation is effective as soon as SVMD 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 SVMD Use Only

Vendor Number _____ Date Received _____