

**AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER**

As part of receiving your funds via EFT you are also agreeing to no longer receive a paper copy of your remittance advice. You can now view/print a copy of your remittance advice using BlueAccess, the secure area of [www.bcbst.com](http://www.bcbst.com)

Indicate (Check One):  Add  Change  Terminate

If Change or Terminate, please indicate reason:  Closed Account  Change of Ownership  
 Other

Provider or Group Name: \_\_\_\_\_

Provider or Group Number: \_\_\_\_\_ Tax ID: \_\_\_\_\_

\*If multiple provider numbers used, please attach a listing of those provider numbers and provider name

I hereby authorize BlueCross BlueShield of Tennessee to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my  Checking /  Savings (check one) account as indicated below and the bank or other institution named below, hereinafter called BANK, to credit and/or debit the same to such account.

BANK Name: \_\_\_\_\_ Branch: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Transit/Routing Number if known (9 Digits): \_\_\_\_\_

Bank Account Number: \_\_\_\_\_ (Please enclose copy of a voided check)

This authority is to remain in full force and effect until BlueCross BlueShield of Tennessee has received written notification from me of its termination at least 60 days prior to the effective date. Failure to provide written notice 60 days prior to the change may result in payments being directed improperly.

This applies to the following lines of business: BlueCare, TennCare Select, CoverTN, CoverKids, Select Community, Choices and BPN

- (1) "This is to certify that the foregoing information is true, accurate, and complete."
- (2) "I understand that payment of this claim will be from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws."

Contact Name: \_\_\_\_\_ Contact Phone #: \_\_\_\_\_

Street Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Date: \_\_\_\_\_ Signed: \_\_\_\_\_

Authorized Signatory Print Name and Title:

Please mail this form and a copy of a voided check to: **BlueCross BlueShield of Tennessee  
ATTN: Provider Information Dept. 2.4CH  
One Cameron Hill  
Chattanooga, TN 37402**

**You MUST include a VOIDED CHECK COPY in order for us to process this request. Thank you!**