



**APEX**  
Benefits Services

Apex Benefits  
Services  
P.O. Box 3620  
Akron, OH 44309-  
3620

Electronic Fund  
Transfer  
Automatic Deposit  
Authorization  
Agreement

I authorize Apex Benefits Services, to initiate credit entries into the account(s) indicated below and authorize the financial institution/bank named below; to credit the same to such account(s).

If the account is drawn in the Physician's or Individual Practitioner's Name, or the Legal Business Name of the Provider/Supplier, the Physician/Provider/Supplier certifies that he/she has sole control of the account(s) below, and certifies that all arrangements between Apex Benefits Services and the said Physician/Provider/Supplier are in accordance with all applicable Medicare regulations and instructions.

This authorization agreement is effective as of the signature date below and is to remain in full force and effect until Apex Benefits Services has received written notice of termination at least 30 days prior to the termination date. If my banking account information changes, I agree to submit the corrections to Apex Benefits Services in an updated EFT Authorization Agreement.

**NOTE:** Apex Benefits Services makes claim payments based on the National Provider Identifier assigned to the provider. When a provider is paid to a group or practice, all other providers under that same group or practice will also be paid by Electronic Fund Transfer.

**Go Paperless:** To discontinue your paper explanation of payment (EOP), check the box below and your EOP/835 will be sent electronically.

Please discontinue my paper EOP and send an 835 (electronic EOP) in its place. YES  NO

**Providers Information**

Provider Name: \_\_\_\_\_

Provider Tax Identification Number: \_\_\_\_\_

National Provider Identifier (NPI): \_\_\_\_\_

Providers Address: \_\_\_\_\_

Providers City, State and Zip Code: \_\_\_\_\_

Providers Phone Number: \_\_\_\_\_

Providers Email Address: \_\_\_\_\_

Contact Name: \_\_\_\_\_

**Banking Information**

**ACCOUNT #1**

Bank Name: \_\_\_\_\_

Bank Routing Number: \_\_\_\_\_

Bank Account Name: \_\_\_\_\_

Bank Account Number: \_\_\_\_\_

Bank Address: \_\_\_\_\_

Bank City, State and Zip Code: \_\_\_\_\_

Bank Phone Number: \_\_\_\_\_

Is this account a Checking or Savings Account? \_\_\_\_\_

Name of person authorizing the Electronic Fund Transfer:

Please Print: \_\_\_\_\_

Signature of person authorizing the Electronic Fund Transfer:

Sign: \_\_\_\_\_ Date: \_\_\_\_\_

Please return this completed form via mail:

Apex Benefits Services  
Attn: EDISUPPORT  
P.O. Box 3620  
Akron, OH 44309-3620

If you have any questions please call Provider Support Services at 330-996-8400, toll free 1-800-996-8401 or send email to [contactproviderservices@summacare.com](mailto:contactproviderservices@summacare.com) .