MMM of Florida, Inc.

Electronic Funds Transfer (EFT) Authorization Agreement

(*Email completed form, voided check or bank letter, and W-9 to:*
providerfinance@mmm-fl.com)

Provider's Name:	**Email:**
Mailing Address:	**Social Security or Tax ID Number:**
Telephone Number:	**National Provider Identifier (NPI) Number:**

I authorize MMM of Florida, Inc. to credit my claim payment to the bank account stated below.

Name of Financial Institution:
Routing Number:
Account Number:
Account Type
☐ **Savings**
☐ **Checking**

This authorization will remain in effect until MMM of Florida, Inc. receives a written notification canceling the Direct Deposit service. I understand that I will send my direct deposit's cancellation request 30 days in advance of the desired effective date.

Provider's Signature _____ Date _____

For MMM of Florida, Inc. internal use only

☐ Capitated (if the provider is capitated please send a copy to the Finance Department)

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The information provided was reviewed and validated and it is correct to the best of my knowledge.

MMM of Florida, Inc. Representative's Signature _____ Date _____