US FAMILY HEALTH PLAN

PROVIDER EFT FORM

Provider/Group TIN: _____

Provider/Group NPI:_____

Provider/Group Name: _____

DBA:

Provider Street: _____

Provider City: _____

Provider State: _____

Provider Zip Code:_____

Financial Institution Name:_____

Routing Number: _____

Account Type (Checking or Savings): _____

Account Number: _____

Representative Name/Title: _____

Representative Phone Number: _____

Representative Email Address: _____

Please send completed form to the Provider Network Department by email, fax, or mail.
Email: provnetwork@svcmcny.org
Fax: 212-356-4868 or 646-612-7693
Mail: USFHP – Provider Network
530 7th Avenue, 10th Floor, New York, New York 10018