



SVC MC, Inc.



US FAMILY
HEALTH PLAN

PROVIDER EFT ENROLLMENT

Provider Information

Select Provider Type: Group _____ Individual _____

Provider TIN: _____

Provider NPI: _____

Provider Name: _____

DBA: _____

Provider Street: _____

Provider City: _____

Provider State: _____

Provider Zip Code: _____

Financial Institution Information

Financial Institution Name: _____

Routing Number: _____

Account Type (Checking or Savings): _____

Account Number: _____

Please send completed form to the Provider Network Department by email or fax:

Email: provnetwork@svcmcnny.org

Fax: 212-356-4868