Florida community care

Electronic Funds Transfer (EFT)/ Automated Clearing House (ACH) Request Form

General Information

☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

Request Effective Date:

Provider Name:

Provider Contact Name:

Provider Address:

Contact Phone #:

Contact Email:

Tax ID Number:

All applicable Billing/Pay to NPI:

Bank Information

ACH Routing Number (ABA #):

Bank Account Number:

Bank Name:

Bank Address:

Check One: ☐ **Savings** ☐ **Checking**

Form Completed By: Date:

1. 30 days are needed to process a request.
2. Please attach a copy of a voided check and a W9.
3. Email to: FCCEFT@FCChealthplan.com or Fax to: (631) 963-4935.

For Internal Use Only

PayID: