EFT (Electronic Fund Transfer)
Pre-Authorization Claims Disbursement Form

You must be registered with a clearinghouse to receive the electronic remittance advice from PreferredOne to enroll in EFT (Electronic Fund Transfer). For more information visit www.aspirushealthplan.com/group-individual/provider-resources/ and select Provider EDI Resources.

PROVIDER INFORMATION

Provider Name		Tax ID Number:	
Mailing Address	City	State	Zip Code

Type of Account *(check one)* ☐ Checking ☐ Savings

Required: Include a voided check or copy with this request. A letter from your financial institution with your business name, bank routing number and account number will also be accepted. We are unable to process your request without proper documentation.

Special Instructions: (include specific NPIs or types of services if applicable)

AUTHORIZATION

The Provider hereby requests that claims reimbursement be made electronically into the financial institution named on attached voided check or financial institution letter. Electronic signatures must be certified.

I represent that I am the account holder and certify under penalty of perjury that I have completely read and fully understand the terms and conditions of this form and that all the representations made by me on this form are true, correct and complete. I understand that there may be consequences for providing false information or omission of relevant information. I understand that I may be subject to penalties under law if I provide false or untrue information.

Provider Contact Name	Provider Contact Email	Provider Contact Phone
Authorized Provider Signature		Date

Please return the completed and signed form to:

Aspirus Health Plan, Inc.
Attn: Provider Database
6105 Golden Hills Drive
Golden Valley, MN 55416

-or-
Fax: (763) 847-4814
-or-
Email: Credentialing@Preferredone.com

60022 02-22 © 2022 Aspirus Health Plan, Inc. All rights reserved.