HealthPartners®

Corporate Office:
8170 33rd Avenue South
Bloomington, MN 55425
www.healthpartners.com

Mailing Address:
P.O. Box 1309
Minneapolis, MN 55440-1309

Dear Valued Business Partner:

HealthPartners, Inc. is pleased to announce Electronic Funds Transfer (EFT) as a preferred payment option. The EFT payment method will speed payment delivery by depositing payments directly to your bank account. Authorizing EFT as your payment method will ensure that your company will have quicker access to funds paid to you. Although payment via EFT is not a requirement, we strongly encourage EFT as your payment method.

To be eligible to receive EFT payments, you must be currently receiving electronic 835 remittance advice transactions from HealthPartners or have an account for viewing and printing on-line remits through the HealthPartners Provider Portal. Please note that paper remits will no longer be provided to EFT customers.

If your company is eligible to receive EFT payments, the following forms will need to be completed and signed by an authorized requester:

- HealthPartners Financial EFT Authorization
- EFT Worksheet (if applicable)
- W-9
- Bank Letter validating account information or void check

HealthPartners will accept authorization of electronic banking information from the following authorized requestors:

- Treasury Department Representative
- Director or Manager of Finance
- Accounts Receivable Manager
- Controller or CFO
- Bank validation letter

Please e-mail or fax the completed signed and dated HealthPartners Financial EFT Authorization, W-9 forms, and Bank Letter to ProviderEDISupport@HealthPartners.com or 952-853-8708. If you do not have access to a fax machine, please mail to:

HealthPartners, Inc.
M.S. 21108C Attention: EFT/Provider E-Commerce
8170 – 33rd Avenue South, P.O. Box 1309
Minneapolis, MN 55440-1309

Once the appropriate forms have been submitted and are properly executed, a representative from HealthPartners Provider E-Commerce will contact you within ten (10) business days to discuss an implementation timeline and finalize your request.

To avoid payment interruption or errors, any changes in depository financial institution or other payments instructions must be provided to HealthPartners Accounts Payable 15 working days in advance.

If you have any questions regarding the attached form, please contact HealthPartners Treasury Department.

Thank you.

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HEALTHPARTNERS FINANCIAL EFT AUTHORIZATION

Form sent to vendors to expedite payment method via ELECTRONIC FUNDS TRANSFER

_____ (to be referred to as "The Company") sells goods and/or services to HealthPartners or one of its related organizations.

HealthPartners agrees to make payments for such goods and/or services by Electronic Funds Transfer (EFT) transactions through the ACH Network and/or Federal Reserve Wire System.

Therefore, The Company hereby (1) authorizes HealthPartners to make payments for goods and/or services by EFT, (2) certifies that it has selected the following depository financial institution, and (3) directs that all such EFTs be made as provided below:

Depository Institution (Bank) Name: _____
Address: _____
Routing Transit Number/ABA #: _____
Account Number: _____
Account Type: _____

Company Contact Info (Required)
Contact Name _____
Phone Number _____
E-mail Address _____

For this depository financial institution only, please specify which organizations the EFT payments will apply to. If you are requesting more than three (3) organizations, please utilize the **EFT Worksheet**.

Billing Provider Name	**Tax ID Number**	**Billing NPI**

The Company acknowledges and agrees that the terms and conditions of all agreements or purchase orders with HealthPartners concerning the methods and timing of payments for goods and/or services shall be amended as provided herein. (Value dates on any EFT payments replacing check payments will be extended three (3) days beyond the date required for check payments.)

The Company will notify HealthPartners of any changes in depository financial institution or other payments instructions 15 working days in advance.

By: _____ Date: _____
(Authorized Signature)

_____ Title: _____
(Please Print Name Legibly) (Please Print Title Legibly)

Do Not Write Below This Line

For HealthPartners Internal Use Only

Vendor Number _____ Effective Date _____
Payment Terms _____ Payment Type _____

Treasury Authorization _____ Date _____

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EFT Worksheet

Billing Provider Name	**Tax ID Number**	**Billing NPI**