HANA HOU
MEDICAL GROUP

Authorization for Electronic Funds Transfer (EFT) Direct Deposit

Check all that apply:

- ☐ Begin EFT Deposit **(new enrollees, please include a copy of a voided check with submission of this form)**
- ☐ Change EFT Deposit
- ☐ Terminate EFT Deposit

I (We) have provided information for the account below. I (We) hereby authorize HHMG, to electronically credit my (our) account and, if necessary, to electronically debit my (our) account to correct erroneous credits. I (We) agree that ACH transactions I (we) authorize comply with all applicable laws.

Account (Select One):

☐ Checking Account ☐ Savings Account

Financial Institution Information:

Financial Institution Name:
Financial Institution Routing Number:
Financial Institution Account Number:
Account Holder's Name:
Account Holder's Tax ID Number:
Provider Office Contact Name, Email, Phone:

I (We) understand that this authorization will remain in full force and effect until I (we) notify HHMG in writing by mail to 1712 Liliha St, Suite 102 Honolulu, HI 96817 that I (we) wish to revoke this authorization. I (We) understand that Hana Hou Medical Group requires at least 30 days' prior notice in order to cancel this authorization.

Provider Name(s):_____

Provider NPI ID(s):_____
(Please Print)

Date_____ Signature_____

FAX BACK TO: HHMG at (888) 847 - 8215