



## Direct Deposit Agreement

\_\_\_\_\_  
**Provider Name (typed or printed)**

\_\_\_\_\_  
**National Provider Identifier (NPI) Type 1  
(Individual)**

\_\_\_\_\_  
**Tax Identification Number**

\_\_\_\_\_  
**National Provider Identifier (NPI) Type 2  
(Organizational)**

I (we) hereby authorize Blue Cross & Blue Shield of Rhode Island (hereinafter called the “Company”) to initiate credit entries to my (our) account indicated below and the depository named below (hereinafter called the “Depository”) to accept such credit entries to such account.

**Financial institution (Depository):** \_\_\_\_\_

**Transit ABA number:** \_\_\_\_\_  
(If unknown, contact bank.)

**Account number to be credited:** \_\_\_\_\_  
(Print exactly as on deposit ticket.)

**Account:**             Business             Personal

**Type of Account:**     Savings             Checking             Other (specify)

This authority is to remain in full force and effect until the **COMPANY** has received written notification from the provider’s authorized agent of termination of this **Direct Deposit Agreement** in such time and in such manner as to afford **COMPANY** and **DEPOSITORY** a reasonable opportunity to act upon it.

\_\_\_\_\_  
**Printed Name of Provider or Authorized Agent**

\_\_\_\_\_  
**Signature of Provider or Authorized Agent**

*Please provide a copy of a voided check that includes your account number and printed name of group or individual. If a voided check is not available or you are using a savings account please supply a letter from the financial institution that includes the account information and routing number.*

**Please fax the completed Direct Deposit Agreement and a copy of a voided check or other documentation to (401) 459-2099 or mail them to:**

Provider Information Management Operations  
Blue Cross & Blue Shield of Rhode Island  
500 Exchange Street  
Providence, RI 02903-2699

Revised 01/10