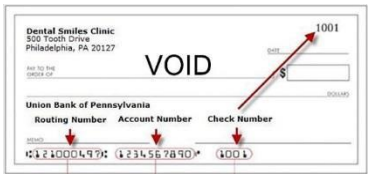
Electronic Funds Transfer (EFT) Authorization Agreement

Get your reimbursement faster and easier with EFT! To receive your payments by EFT, please complete this form and return it with a scanned or faxed copy of a voided check. *(This Authorization Agreement will not be valid without a* voided check.*)*

Submission Options	
Send this completed form and voided check to Molina Healthcare via:	**Fax:** 844-584-3686 *or* **Email:** PROVIDERSERVICES@SKYGENUSA.COM
Submission Reason	
Select one checkbox.	❑ New EFT Authorization | ❑ Account or bank change to existing EFT Authorization

Provider Information		
Provider Name *(Include d/b/a, if any.)*	Taxpayer Identification Number	*Select one checkbox.* ❑ SSN | ❑ EIN
Street Address		
City	State	Zip Code
Phone Number	Email Address	

Financial Institution Information	
Financial Institution Name	Financial Institution Routing Number *(Include 9 digits with any leading zeros.)*
Account Number *(Include up to 10 digits with any leading zeros.)*	*To indicate account type, select one checkbox.* ❑ Checking Account | ❑ Savings Account
Note: Please return this form with a *voided check* or the Authorization Agreement will not be valid.	

Authorization

I hereby authorize Scion Dental, on behalf of itself and its affiliates, (hereinafter "Company") to initiate credit entries to the account at the financial institution listed above for all payments. I authorize and request the financial institution to accept credit entries by Company to such account and to credit the same to such account. If Company credits more money than the correct payment amount due to duplicate electronic funds transfers (where "duplicate" is defined as multiple electronic funds transfers received for the same services rendered, the same membership, and the same dates of service) or erroneous electronic funds transfers (where "erroneous" is defined as complete electronic funds transfers received in error) I authorize Company to withdraw the overpayment electronically. I accept responsibility for any resulting loss of payment and release Company from any liability for or arising from my failure to submit accurate or updated information to Company. I understand that I must communicate any changes in my information to Company. This authorization is effective as of the signature date below and is to remain in full force and effect until Company has received written notification from me of its termination or Company notifies me that this service has been terminated. I agree to provide notification of change/termination 30 days in advance. By signing this authorization, I acknowledge that I have read and agree to the conditions set forth herein. Furthermore, I certify that the information provided is true and accurate in all respects and that I have been duly authorized to enter into this agreement.

Printed Name	Title
Authorized Signature	Date

