BlueCross BlueShield of North Carolina

An independent licensee of the Blue Cross and Blue Shield Association

ECHO HEALTHCARE PAYMENT SYSTEMS

AUTHORIZATION & GUARANTEE AGREEMENT FOR AUTOMATED CLEARING HOUSE (ACH) AUTHORITY

Dental Service Provider:

Name_____

Billing Address (number, street) _____

(city, state, zipcode)_____

Tax ID Number ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

E-mail address _____

Additional e-mail address (optional) _____

Additional e-mail address (optional) _____

Dental Service Provider hereby authorizes ECHO Health, Inc. hereinafter called "ECHO," to initiate credit entries for approved benefit plan payments to said Dental Service Provider's account identified hereinafter as "Depository."

I also understand that this authority is to remain in full force and effect until ECHO has received written notification from Dental Service Provider of its termination in such time and in such manner as to afford ECHO a reasonable opportunity to act on it, which in any way shall be not less than ten banking days after receipt.

BANK DEPOSITORY NAME _____

BANK DEPOSITORY ADDRESS _____

(address number, street)

_____

(city, state, zip code)

Transit/ABA No. ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

(First number on account)

Account No. _____

(Second number on account)

Approval

Executed By (print name) _____ Title _____

Phone _____ E-mail _____

Date _____ Executed By (signature) _____

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