

**AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER
(EFT)
AUTOMATIC DEPOSITS/PAYMENTS**

This form must be completed by individual provider groups or businesses who will be receiving funds directly from Magellan Health Services, Inc. and/or its subsidiaries.

I (we) hereby authorize Magellan Health Services' Administration, to make deposits to my (our) checking/savings account and the depository bank indicated below, hereinafter referred to as "Depository", to credit the same to such account.

DEPOSITORY NAME: _____

CITY: _____ **STATE:** _____ **ZIPCODE:** _____

BANK PHONE #: _____

CHECKING or **SAVINGS**

A Bank representative should be contacted to confirm below information:

BANK TRANSIT/ABA NUMBER: _____

BANK ACCOUNT NUMBER: _____

BANK ACCOUNT NAME: _____

This authority is to remain in effect as long as I (we) receive payments. I understand that this electronic funds transfer deposit/payment will be from Magellan Health Services, Inc.

CONTACT NAME & PHONE # _____

DATE: _____ **AUTHORIZED SIGNATURE:** _____

(The person(s) signing this form must be authorized to sign on this account).

PLEASE ATTACH A BLANK VOIDED CHECK OR DEPOSIT SLIP TO THIS FORM.

Please return form to:

Magellan Health Services, Inc.
Treasury Department
6950 Columbia Gateway Drive
Columbia, Maryland 21046

or fax to
410-953-5248