TRIPLE-S SALUD
BlueCross BlueShield of Puerto Rico

EFT ENROLLMENT FORM (PROVIDER)

PROVIDER INFORMATION

Provider Name:	
Address:	
City, State and Zip:	
Contact Name:	Email Address:
Telephone No.:	Fax No.:
Tax ID No.:	Provider of NPI Number:

FINANCIAL INSTITUTION INFORMATION

Nine-Digit Routing Transit Number:	
Account Number:	
Account Name:	
Type of Account: ☐ Checking ☐ Savings	
Bank Name:	Bank Branch:

I authorize Triple-S Salud to make electronic credits to my accounts in the above specified financial institution.

Submission Information

Reason for Submission: New Enrollment: ☐ Change Enrollment ☐	
Authorized Signature:	Date: (month/day/year)

THIS SECTION COMPLETED BY PROVIDER:

Authorized Signature:	Date: *(month/day/year)*

Triple-S Salud, Inc. has the right to adjust future payments or debit to the provider's account via ACH if payments previously made are found to be duplicated, in excess of requirements, fraudulent of in error.

Return this completed form to A/P via email to: **approvider@ssspr.com**
Please include a voided check or deposit slip

Applicable Term:

1. This authorization will be in effect until a provider's cancellation letter is received, and reasonable time is given to the company and the bank to process the request.
2. Said notice should be delivered in our offices, mailed to Triple-S Salud, Attn. Accounts Payable Department, PO Box 363628, San Juan PR 00936-3628, by fax at 787-749-4190 or via email to approvider@ssspr.com.
3. If any changes occur on the banking account, it is the provider's responsibility to notify it with thirty (30) days in advance and complete a new application.
4. The bank's monthly statement will serve as payment receipt.
5. Triple-S Salud, Inc. reserves the right to finalize this payment method and your enrollment in said system.