Reset Form

Horizon Blue Cross Blue Shield of New Jersey

Automated Clearinghouse Authorization Agreement

Horizon Dental is hereby authorized to credit our bank account through the Automated Clearinghouse (ACH) for the **Total Amount Owed** according to the Claims submitted.

Provider Name: _____

Provider ID: _____

ACH Effective Date: _____

Account Name: _____

Type of Account: ☐ Checking ☐ Savings

Bank Name: _____

Bank Address: _____

Bank Account Number: _____

Bank Routing Number: _____

(between these symbols ⑆ ⑆ on the bottom left of your check)

PLEASE INCLUDE A VOIDED CHECK

Authorized individual of the Account: _____
Print

_____
Signature Today's Date

_____
Title Telephone Number

I understand that this authorization will be in effect until I notify Horizon in writing that I no longer desire this service, allowing 10 business days upon receipt to act on my notification.

If you have any questions, please call 1-855-648-1403 option 5. Upon completing this form, please forward along with a copy of voided check to fax number 1-877-631-8953 or e-mail to: **ProviderEFT@horizondentaladmin.com**

Or mail to: Horizon Dental BCBSNJ
ATTN: EFT Department
P O BOX 1612
Minneapolis, MN 55440-1612