CIGNA HealthCare
Direct Deposit Unit C3DDS
900 Cottage Grove Road
Hartford, CT 06152-1328

CIGNA HealthCare
Direct Deposit Authorization Form

Please read the instructions prior to completing this form.

PROVIDER NAME *(Legal Entity)*	TAX IDENTIFICATION NUMBER
PROVIDERS BILLING ADDRESS *(Street, City, State, Zip Code)*	
CONTACT NAME	Telephone ( )

PLEASE INCLUDE A VOIDED CHECK OR SPECIFICATION SHEET AS REQUESTED IN THE INSTRUCTIONS. YOUR APPLICATION CANNOT BE PROCESSED WITHOUT THIS INFORMATION.

NOTE: A VOIDED DEPOSIT TICKET IS NOT ACCEPTABLE.

Please Check One:

☐ **Cancellation** ☐ **Enrollment** ☐ **Change**

BANK ACCOUNT INFORMATION

BANK ACCOUNT NUMBER	BANK ROUTING NUMBER
BANK ACCOUNT NAME	

LISTED NUMBER REFERS TO: (Please Check One)

☐ Business Checking Account ☐ Business Savings Account ☐ Other (personal account, etc.)

BANK NAME	
ADDRESS *(City, State, Zip Code)*	

Authorization is hereby granted CIGNA HealthCare, Inc. to credit said account at the financial institution named above for the purpose of transferring CIGNA HealthCare, Inc. payments. CIGNA HealthCare, Inc. is also granted authorization to correct inadvertent duplicate payment information. This authorization is to remain in effect until notification is given to CIGNA HealthCare, Inc. in writing (at least ten (10) days notice) on a CIGNA HealthCare Direct Deposit Authorization Form advising of a change, allowing reasonable time to implement such change.

AUTHORIZATION SIGNATURE	PRINTED NAME AND TITLE	DATE

INSTRUCTIONS TO PROVIDER

Please read before completing the Authorization Form.
Direct Deposit is available to all CIGNA HealthCare Providers.

1. Use this form for enrollment, cancellation of a service, or a change. If changes are made to a Bank Account (e.g., financial institution or a new account number), another application must be filed with CIGNA HealthCare, Inc.

2. To ensure clear, readable copies, please type or print clearly all requested information.

3. **Provider Name:** Please use the full name of the Provider. This name must match the legal entity associated with the TIN (Tax Identification Number). Only one authorization form should be completed for each TIN.

4. **Tax Identification Number:** Please provide the 9 digit number associated with the legal entity.

5. **Provider's Billing Address:** City, State and Zip Code.

6. **Contact Name:** Please provide the name of the individual who should be contacted if this form is incomplete or requires additional information.

7. **Telephone Number:** Please provide the telephone number of the Contact Person.

8. **IMPORTANT INFORMATION:**
A VOIDED CHECK FOR THE ACCOUNT(S) OR A MICR ENCODED SPECIFICATION SHEET (WHICH CAN BE OBTAINED FROM YOUR BANK) MUST BE INCLUDED WITH THIS AUTHORIZATION FORM. PLEASE NOTE: A DEPOSIT TICKET IS NOT ACCEPTABLE.

9. Funds can be electronically credited to any commercial account if the Financial Institution is a member of an Automated Clearing House (ACH). You can confirm this by contacting your Bank.

10. **BANK ACCOUNT INFORMATION:**
Bank Account Number - The account number to which CIGNA HealthCare Direct Deposits will be made.
Bank Transit/Routing Number - The nine digit number that identifies your Bank -usually found in the lower left corner of your check. Verify with your Bank.
Bank Account Name – Provider, Group or Business name associated with the Bank Account Number.
Bank Name – Identify the full name of your Financial Institution (e.g. Your Bank, N.A.).
Address – the Street Address, City, State and Zip Code for your bank.

11. Please sign and date the form.

12. Please retain a copy for your records. Send a copy to:

CIGNA HealthCare, Inc.
Direct Deposit Unit, C-328
900 Cottage Grove Road
Hartford, CT 06152-1328
Fax # 860-226-5911