OKLAHOMA STATE AND EDUCATION EMPLOYEES GROUP INSURANCE BOARD

*Oklahoma Department of Rehabilitation Services*

# Electronic Funds Transfer (EFT) Form

**SUPPLIER ONLY:**

Legal Name of Corporate Owner: _____

Trade Name/dba:: _____ Federal Tax ID #: _____

**PRACTITIONER ONLY:**

Practitioner's Name: _____

SSN: _____ Federal Tax ID #: _____

## *BANKING INFORMATION*

A voided check is required. If the bank account does not have checks, a bank letter verifying the account and routing numbers will be accepted.

A deposit slip will be accepted only if the information provided below matches the MICR line containing the banking ABA number and account between these symbols | : |:

Financial Institution: _____

Account Number: _____ Routing Number: _____

☐ Checking ☐ Savings

## *BILLING/REMIT*

Name Submitted on Claims: _____

Billing Office Name (if applicable): _____

Billing Address: _____

_____

(City) (State) (Zip)

## *AUTHORIZED SIGNATURE*

Signature: _____ Date: _____

(Required)

Printed Signature Name: _____ Phone: (_____)_____

Please mail, fax or email the completed form to:

Department of Rehabilitation Services
Attn: Provider Relations
P.O. Box 57630
Oklahoma City, OK 73157
Phone: 405-717-8921 or 1-888-835-6919
Fax: 405-717-8977
oseegibproviderrelations@sib.ok.gov