Medical Practice Consortium
Authorization for Direct Payment Via ACH (ACH Debit)
Instructions

The Medical Practice Consortium requires insured medical practices to make automatic ISMA/Anthem health insurance premium payments directly from their checking accounts.

When you sign up for the Direct Payment Via ACH Plan, your Anthem health insurance premiums will be deducted electronically from your bank account between the 25th and the final day of each month, for the following month's premiums.

To join the Direct Payment Via ACH (ACH Debit) Plan:

1. Print the attached Payment Authorization Form.
2. Read the Terms and Conditions
3. Complete and sign the form.
4. Fax it to us at 1-317-261-2238 ***with a copy of a voided check to allow us to verify the bank routing number and account number***.

ISMA will email you to confirm enrollment, and will provide you with a copy of each monthly billing statement for your records.

Please call the Medical Practice Consortium Administration Team at (800) 257-4762 if you have any questions.

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Direct Payment Via ACH is the transfer of funds from a consumer account for the purpose of making a payment.

I (we) agree that ACH transactions I (we) authorize comply with all applicable law. I (we) authorize the Medical Practice Consortium to electronically debit my (our) account (and, if necessary, electronically credit my (our) account to correct erroneous debits) as follows:

Anthem Group Number (from billing statement) _____

Name of Account Holder _____

Financial Institution Name/City/State _____

Routing # _____ Account # _____

To assist in verifying this account, please attach a voided check or a copy of a cleared check *previously issued to the Medical Practice Consortium paying insurance premiums from this account.*

I (we) authorize debit of the balance owed as reflected on the Group Health Insurance Billing Statement to be processed between the 25th and the final day of the month prior to the month(s) of coverage. I (we) understand that if any payment is returned by the Financial Institution for any reason, I (we) will be responsible for NSF and/or administration charges.

I (we) understand that this authorization will remain in full force and effect until I (we) notify the Medical Practice Consortium in writing by mail to the address above or by fax to (317) 261-2235 that I (we) wish to revoke this authorization. I (we) understand that the Medical Practice Consortium requires at least 3 weeks prior notice in order to cancel this authorization.

Name of Authorized Signer _____ Date _____

Signature of Authorized Signer _____

Email Address _____

FOR MEDICAL PRACTICE CONSORTIUM ADMINISTRATION USE ONLY

_____ Date entered in banking system

_____ Date pre-noted

_____ Date entered in billing system, confirmed