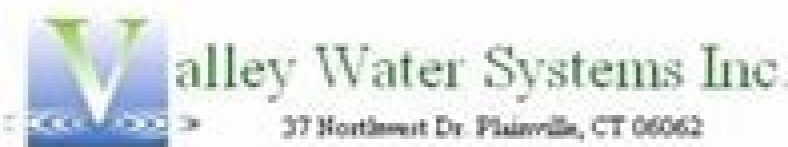




I'm not robot



**Open**



ACH Payment Authorization Form

Please sign and complete this form to authorize VWS to make a monthly ACH debit from your bank account. Once you have completed this form please attach a voided check of the account you wish us to debit from for verification and security purposes.

By signing this form you give Valley Water Systems Inc. permission to debit your account the total amount due as indicated on your VWS bill. This is permission for monthly transactions to be debited on the 15th of each month, and does not provide authorization for any additional unrelated debits or credits to your account.

For your initial setup a completed authorization form along with a voided check must be submitted by the 10th to have your account debited by the 15th of that same month. If the 15th falls on a weekend payment will be processed the next business day. Written cancellation of this agreement must be submitted to our office within 5 business days of the next scheduled debit.

Please complete the information below:

I \_\_\_\_\_ (Customer Name) authorize Valley Water Systems to charge my bank account indicated below the total amount due as indicated on my VWS bill on or after the 15th of each month.

Name \_\_\_\_\_
Billing Address \_\_\_\_\_ Phone# \_\_\_\_\_
City, State, Zip \_\_\_\_\_ Email \_\_\_\_\_

Name on Account: \_\_\_\_\_
Bank Name: \_\_\_\_\_
Bank Account Number: \_\_\_\_\_
Bank Routing #: \_\_\_\_\_
Bank City/State: \_\_\_\_\_
This Bank Account is Enabled for ACH Transactions  Yes  No

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_


NAME (printed) \_\_\_\_\_

I certify that I am an authorized user of the bank account as stated above and that I have the authority to authorize this payment on the accounts behalf. I understand that because this is an electronic transaction, these funds may be withdrawn from the account as soon as the above noted transaction date. In the case the transaction is returned for Non Sufficient Funds (NSF) I agree to an additional \$25.00 charge for each attempt returned NSF, which will be added to your VWS account balance. I have certified that the above bank account is enabled for ACH transactions, and agree to reimburse Valley Water Systems for all penalties and fees incurred as a result of my bank rejecting ACH debits or credits as a result of the account not being properly configured for ACH transactions. Both parties agree to be bound by NACHA Operating Rules as they pertain to this transaction. I acknowledge that the origination of ACH transactions to its account must comply with the provisions of U.S. law. I agree not to dispute this transaction with my bank or Valley Water Systems Inc. provided the transaction corresponds to the terms indicated in this authorization form.

Blue Cross of Michigan Prior Authorization Form. Includes sections for Patient Information, Provider Information, and Request Information.

Kentucky Medicaid MCO Prior Authorization Request Form. Includes sections for Member Information, Request Information, and Medical Information.

Blue Cross of Michigan Request for Prior Authorization Form. Includes sections for Member Information, Request Information, and Medical Information.

MEDICAL PRIOR AUTHORIZATION REQUEST	
 Fax the completed form to: North Florida Market (800) 929-5842 & Central/South Florida Markets (800) 528-2705 or call (888) 853-2629 for Summit/Advantra & (800) 447-3725 for Medicaid, Healthy Kids, Medicare, Commercial	
<b>Priority:</b>	<input type="checkbox"/> Stat (24 hours) <input type="checkbox"/> Urgent Emergent (72 hours) <input type="checkbox"/> Routine Request (4-14 days)
<b>Product:</b>	<input type="checkbox"/> Commercial/Individual <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Healthy Kids
<b>Provider Information</b>	
<b>Patient Information</b>	
Name:	Name:
Address:	Member ID:
City, Zip Code:	DOB:
Phone:	Date of Request:
Fax : (Required to process authorization)	
Contact Person:	
SERVICE REQUESTED: Fax Clinical / Plan of Treatment for Request	
Service Requested:	DOS:
Diagnosis:	* ICD - 9 Code(s) : (Required to process authorization)
CPT Code(s) : (Required to process authorization)	Phone Number:
Provider / Facility:	
Address:	
City, Zip Code:	
Procedure:	
<input type="checkbox"/> Inpatient Surgery <input type="checkbox"/> Outpatient Surgery <input type="checkbox"/> Other	
CLINICAL INFORMATION WITH SUPPORTING DOCUMENT(S) (Required to process authorization)	
Primary Care Physician Signature: _____	
<b>SERVICE PROVIDER INSTRUCTIONS</b>	
<ul style="list-style-type: none"> <li>1 All fields in form MUST be completed for your authorization to be processed</li> <li>1 Authorization is not a guarantee of payment</li> <li>1 Verify member eligibility and benefits prior to rendering service</li> <li>1 Submit claim to the address on the member's ID card</li> <li>1 Specialty network physicians should follow network guidelines</li> </ul>	
AUTHORIZATION APPROVAL (To be completed by the plan)	
Authorization # :	Date Issued:

Form # 749VMPR

Step 8A Below List Diagnoses, write the diagnoses relevant to this request and their associated ICD-9/ICD-10 codes. Important Note: If you change from a Medicare Advantage plan that includes prescription drug coverage to a Medicare prescription drug plan, this will disenroll you from your Medicare Advantage plan. Contact us Chat with us now IMPORTANT: In the coming days, we will be migrating systems for our evoCore positions. You will return to Original Medicare if you switch from a Medicare Advantage plan (with drug coverage) to a Medicare prescription drug plan. Step 9A Required Clinical Information section, write your clinical justifications for making this request in the blank field and, if you are attaching supporting medical documentation, check the checkbox marked Attachments. Step 10A When you have finished filling out the document, you will need to provide the prescriber's signature and the date. If you do not intend to leave our site, close this message. Beginning Friday, December 18th at 5:00pm EST, you will be able to apply to evoCore openings. If you leave us during the annual election period, your last day of coverage is usually Dec. Step 3A Next, in the Insurance Information section, you must provide the name and ID number of the patient's primary and, if applicable, secondary insurance providers. On the prior authorization form, the person making the request must provide a medical rationale as to why the chosen medication is necessary for the patient in question. You may also download, complete and submit a disenrollment form use the PDF link for your plan below to print its form: Medicare Advantage Plan Disenrollment Form Medicare Advantage Plan Disenrollment Form - A Please complete the relevant form and mail it to: Aetna PO Box 7405 London, KY 40742 Timing Considerations: If there are 10 days or fewer left until the end of the month, please fax the form to 1-866-756-5514. The information you access is provided by another organization or provider. Step 6 Enter the patient name and ID number in the fields at the top of page 2. Step 7 Next, indicate if the patient has tried other medications to treat this diagnosis and list the name, duration of therapy and reason for failure for each applicable prescription. 31. We are still hiring for other open positions so continue the job search at Cigna.com/careers Updated December 30, 2021 Pre-prescription authorization forms are used by doctors who wish to apply for insurance coverage for non-preferred prescriptions. A non-preferred drug is a drug that is not listed in the Preferred Drug List (PDL) of a given insurance provider or state. Update provider data Ati A your options. Like joining a plan, there are only a few times when you can unsubscribe. 1. Address, phone number and exercise changes It's easy to update a provider address, phone number, fax number, email address or initiate an out-of-state transfer or change in the provider group. Once completed, this form should be faxed or e-mailed to the correct directory for the processing of Step 1. At the top of the Global Prior Authorization Application Form for Medical Prescription, you will need to provide the name, telephone number and fax number for the Medical Plan/Group Name. Step 2 Step 2 is complete In Step 1, gender, height, weight, allergies (if applicable), and information (if known). Step 5 Under Medical and Dispensary Information, enter the name of the drug where indicated and indicate if it is a new drug emoc emoc e , atarud al , aipareted alled oizini id atad al erinrof oirassecen A , ovonnir nu id attart is eS , ovonnir nu id o patient has received this medicine. Step 4 "In "Information about the prescriber", you will need to enter the full name, specialization and full address of the prescriber, the name of the applicant (if different from the prescriber), the NPI number, the telephone number, the DEA number, the fax number and the E-mail address. All relevant clinical data and medical documents must also be attached at the time of submission to the insurer. Next, provide the dose/dosage, frequency, duration of therapy/number of refills, quantity, method of administration and site of administration from the prescriber. If the patient has tried a preferred drug for the treatment of the diagnosis, the duration of therapy and the reason for the failure will be described in the form as a justification to support the request.

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