REQUEST FOR DIRECT DEPOSIT AND ELECTRONIC EXPLANATION OF BENEFITS

Wellstar Health Plan

EMPLOYEE INFORMATION		
Employee Name	Date of birth	Last four of SSN
Employer Name	Group #	

PLEASE PROVIDE YOUR E-MAIL ADDRESS IN THE SECTION BELOW TO SIGN UP FOR ELECTRONIC EOBS (EXPLANATION OF BENEFITS)	
E-mail Address	By providing my e-mail address, I agree to receive EOBs from ECHO Health Inc. on behalf of Wellstar Health Plan.

PLEASE PROVIDE YOUR BANK ACCOUNT INFORMATION IN THE SECTION BELOW TO SIGN UP FOR DIRECT DEPOSIT OF ANY MEDICAL BENEFIT REIMBURSEMENTS.		
Bank Name	Routing Number	Account Number

By providing my banking information, I agree to receive electronic payment for any funds due back to me for all services administered by Wellstar Health Plan.

The account specified above must be held by the member. **A voided check must be provided with this form for a checking account. We cannot accept copies of deposit slips.**

If this is a savings account, please indicate that here in lieu of sending a voided check: ☐

PLEASE RETURN SIGNED DOCUMENT TO:	
By Mail: Wellstar Health Plan Attn: Client Accounting P.O. Box 83301 Lancaster, PA 17603	**By E-mail:** CustomerService@WellstarhealthPlan.org **By Fax:** 877-411-4852 **By Portal:** Select New Message in the Messages tab. Select Browse to include this form as an attachment. Select Send.

DISCLAIMER: BY SIGNING THIS DOCUMENT I AGREE TO RECEIVE ELECTRONIC EXPLANATION OF BENEFITS AND/OR DIRECT DEPOSITS OF REIMBURSEMENTS FROM WELLSTAR HEALTH PLAN. I REALIZE THAT THIS CAN TAKE 4 TO 6 WEEKS TO BE IMPLEMENTED.

Employee SIgnature	Printed Name	Date

If you have questions, contact the Wellstar Health Plan Concierge Team by calling 1-833-932-3912