Payment Option Form

network health

Name: _____ **Medicare Number:** _____

Home Phone Number: _____ Date of Birth: _____

Permanent Street Address (P.O. Box is not allowed):

Street: _____ Apt. #: _____

City: _____ County: _____ State: ___ Zip: _____

Mailing Address (only if different from your permanent address):

Street: _____ City: _____ State: ___ Zip: _____

PAYING YOUR PLAN PREMIUM

Please select a premium payment option.

❑ Pay via check. You will receive a paper bill each month between the 15th and 20th of each month indicating your balance due.

❑ Electronic funds transfer (EFT) from your bank account each month. Please enclose a **VOIDED** check or provide the following.

Account Holder Name: _____ Account Type: ❑ Checking ❑ Savings

Bank Routing Number: _____ Bank Account Number: _____

❑ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.) This payment option will not cover the additional Say Cheese Dental Network premium. Unless you enroll in electronic payments, you will receive a monthly invoice requesting a separate payment for that premium.

❑ Credit Card. Log in to your member portal at **login.networkhealth.com**. Select **My Costs** in the upper right corner, then **Make a Payment**. Complete the information on the form and click **Save Payment Options**. If you prefer to have someone from Network Health call you to take your credit card information over the phone, please complete this information.

Contact Name: _____ Contact Phone Number: _____

I hereby authorize Network Health to initiate automatic withdrawals from my account at the financial institution listed on this form. I also authorize Network Health to make deposits into this account in the event of a transaction error.

Signature: _____ **Today's Date:** _____

If you are the authorized representative, you must sign above and provide the following information.

Name: _____

Street: _____ City: _____ State: ___ Zip: _____

Phone Number: _____ Relationship to Enrollee: _____

Please submit this form to: **Attn: Accounts Receivable**
Network Health Medicare Advantage Plans
1570 Midway Pl.
Menasha,WI 54952