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.)

❑ Credit Card. Please Provide the following information. The monthly premium will be deducted around the 7th of each month.

Type of Card: _____ Account Holder Name: _____

Account Number: _____ Expiration Date: _____

Signature: _____ **Todays 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