

CalCPA Health
Registration form for Electronic Billing

Firm Name: _____

Client Code: _____

Please provide contact information on the HR professionals who will require access to the CalCPA Health system for Electronic Billing.

Name	Email	Phone
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Name	Email	Phone
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Please check if you would prefer to no longer receive a hard copy of your invoice.

I agree to the following:

1. The users listed above have appropriate clearance established by the employer to have access to confidential billing and payment information.
2. User IDs and passwords issued to Electronic Billing system users are confidential information and specific to each user. The specific user IDs and associated passwords are not to be transferred to anyone else. The employer is responsible for notifying Banyan Administrators whenever a system user is either terminated or should no longer have access to the Electronic Billing system.
3. I understand that it is our responsibility to view our group's invoice each month and remit payment by the due date and that coverage will be terminated if payment is not received within the accepted grace period.

Signed: _____ Date: _____

Printed Name: _____

Title: _____

Once this form is returned, Banyan Administrators will contact you to provide access to the system and user instructions.

Please return to Banyan Administrators
Fax number: (877) 237-4519
Email address: calcpahealth@fnrm.com