EFT Enrollment Form
Montana Cancer Control Program

Date: _____

Provider Name: _____

Tax ID: _____

Remit Address: _____

Type of Account: ◉ Checking ○ Savings

Routing Number: _____

Account Number: _____

Contact Name: _____

Email: _____ Phone: _____

We do not currently have the means to submit Electronic Remittance Advices. How would you like to receive EOBs?

◉ Encrypted Email: _____
○ Fax: _____

Please attach a copy of a voided check and a current W9 with submission of form.

Please return completed form and required information to Montana Medical Billing one of the following ways:

Morgan Williams
Email: mwilliams@mtmedicalbill.com
Fax: 406-227-7425