



REMITTANCE AGENT DESIGNATION

I, _____ hereby designate and authorize _____, to act as my remittance agent for all claims submitted to Capital District Physicians' Health Plan, Inc. and its wholly owned subsidiaries (collectively "CDPHP"). I direct CDPHP to send all remittance and/or claims reimbursement checks for services that I have provided for CDPHP members to the following named remittance agent:

Name: _____

Address: _____

Tax I.D. Number: _____

Effective Date: _____

Signature: _____

(Print Name)

(Provider Number)

(Date)

Return form to:
CDPHP
500 Patroon Creek Blvd
Albany, NY 12206