Alabama Medicaid Electronic Financial Transaction (EFT) Authorization Agreement

Electronic Funds Transfer (EFT) is the required payment method to deposit funds for claims approved for payment. These funds can be credited to either checking or savings accounts, directly into a provider's bank account, provided the bank selected accepts Automated Clearing House (ACH) transactions. EFT also avoids the risks associated with mailing and handling paper checks, ensuring funds are directly deposited into a specific account.

Provided below are instructions regarding completion of this form. In addition, an Appendix available at the bottom of this form to assist you in correctly completing the form field by field. Please, do NOT mail or fax this page or the Appendix when submitting the EFT Authorization Agreement.

The EFT Authorization Agreement may be used to **newly enroll** a provider in EFT and/or **change an existing EFT**.

To complete an EFT Authorization Agreement you will need to know or be able to obtain all or some of the following information:

- National Provider Identifier
- Basic Business Office Data (i.e., address, phone, fax, email address, etc.)
- Specific Office Data (i.e., vendor information, contact information, etc.)
- IRS Tax Identification Data
- Banking Information

To submit the EFT Authorization Agreement you must:

- Complete all required fields, verifying data is accurate.
- Print the form and obtain the written signature of the person authorized to add or change EFT for the provider.
- Mail or fax the form, not including this guide page or the appendix, to HPES Provider Enrollment at:
  P.O. Box 241685, Montgomery, AL 36124-1685
  – OR–
  301 Technacenter Drive, Montgomery, AL 36117-6008.
  Fax # 334-215-4298.
- Along with the form you must also submit a voided check or letter from the bank for account information verification purposes. Deposit slips, starter checks, handwritten or altered checks will not be accepted. The banking information on the voided check/bank letter must match what is listed on the form.

If you have concerns/questions regarding the completion of the EFT Authorization Agreement you may contact HPES Provider Enrollment toll free at 1-888-223-3630.

If you have concerns/questions regarding CAQH Core ACA Phase III Operating Rules, such as performing reassociation of EFT and ERA – OR – how to resolve of late or missing EFT or ERA, please browse our CAQH Core webpage at: http://medicaid.alabama.gov/CONTENT/6.0_Providers/6.5.2_Phase_III.aspx.

Provider Information

Provider Name

Provider Address

Street (NOT a P. O. Box)

(Suite, Room, etc.)

City

State/Province

Zip Code/Postal Code

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)

National Provider Identification (NPI)

Other Identifier(s)

Assigning Authority

◯ Medicaid

Provider Contact Information

Provider Contact Name

Title

Telephone Number

Telephone Number Extension

Email Address

Fax Number

Provider Agent Information

Provider Agent Name

Provider Agent Contact Name

Telephone Number

Email Address

Financial Institution Information

Financial Institution Name

Financial Institution Address

Street

(*Suite, Room, etc.)*

City | State/Province | Zip Code/Postal Code

Telephone Number | Telephone Number Extension

Financial Institution Routing Number

Type of Account at Financial Institution

☐ Checking Account ☐ Savings Account

Provider's Account Number with Financial Institution

Account Number Linkage to Provider Identifier

☐ National Provider Identifier (NPI)

Submission Information

Reason for Submission

☐ New Enrollment ☐ Change Enrollment

Include with Enrollment Submission

☐ Voided Check ☐ Bank Letter

Authorized Signature

I (we) hereby authorize Alabama Medicaid Agency to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I (we) am responsible for the validity of the information on this form. If the company erroneously deposits funds into my (our) account, I (we) authorize the company to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay period.

I (we) agree to comply with all certification requirements of the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by the Alabama Medicaid Agency or its fiscal agent. I (we) understand that payment claims will be from federal and state funds, and that any falsification, or concealment of material fact, may be prosecuted under federal and state laws.

I (we) will continue to maintain the confidentiality of records and other information relating to recipients in accordance with applicable state and federal laws, rules, and regulations.

Written Signature of Person Submitting the Enrollment

Printed Name of Person Submitting Enrollment

Printed Title of Person Submitting Enrollment

Submission Date

The following page provides an explanation of the fields on the EFT Authorization form and the expected entry:

Field	Description
Provider Name	Enter the name of the provider to whom payments should be made. This name should be the same as what is shown on the bank account, the provider file and on supporting documentation. Supporting documentation being a voided check OR letter from the bank which will need to be submitted along with this EFT Authorization Agreement.
Provider Address	Street, City, State/Province and Zip Code/Postal Code – Enter the full address of the provider for which this EFT Authorization Agreement applies.
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (FEIN)	Enter the Tax ID associated with the provider for which this EFT Authorization Agreement applies.
Provider National Provider Identifier (NPI)	Enter the NPI associated with the provider for which this EFT Authorization Agreement applies.
Other Identifier	Enter the Medicaid ID assigned to the provider for which the EFT Authorization Agreement applies.
Assigning Authority	Click the Assigning Authority of the Other Identifier previously mentioned. The available selection contains the term Medicaid as this is the only Other Identifier allowed.
Provider Contact Name	Enter the name of the person, associated with the provider, who should be contacted with questions regarding this EFT Authorization Agreement.
Title	Enter the title of the Provider Contact previously mentioned.
Telephone Number and Telephone Number Extension	Enter the full phone number as well as a specific phone line extension, if extension is known, for the Provider Contact previously mentioned.
Email Address	Enter the full email address for the Provider Contact previously mentioned.
Fax Number	Enter the full fax number for the Provider Contact previously mentioned.
Provider Agent Name	Enter the name of the Agent who may be working on behalf of the provider such as a Credentialing Agent/Agency.
Provider Agent Contact Name	Enter the name of a contact for the provider's Agent previously mentioned.
Telephone Number	Enter the phone number of the provider's Agent previously mentioned. If an Agent contact is listed this should be the phone number of the Agent contact.
Email Address	Enter the email address of the provider's Agent previously mentioned. If an Agent contact is listed this should be the email address of the agent contact.
Financial Institution Name	Enter the name of the Financial Institution with which the bank account is held.
Financial Institution Address	Street, City, State/Province and Zip Code/Postal Code – Enter the full address of the bank with which the bank account is held.
Financial Institution Telephone Number and Telephone Number Extension	Enter the full phone number as well as a specific phone line extension, if extension is known, for the bank with which the bank account is held.
Financial Institution Routing Number	Enter the routing number of the bank account.
Type of Account at Financial Institution	Select the type of account held with the bank.
Provider's Account Number with Financial Institution	Enter the account number of the bank account; Enter ONLY numeric values; no hyphens, spaces or other special characters.
Account Number Linkage to Provider Identifier/Provider National Provider Identifier (NPI)	Select National Provider Identifier (NPI) as this is the method under which the account will be linked.
Reason for Submission	Select a reason for which you are submitting the EFT Authorization Agreement.
Include With Enrollment Submission	Select the type of supporting documentation which will be submitted with the form as either a voided check OR letter from the bank is required for validation purposes.
Written Signature of Person Submitting the Enrollment	Upon printing the form, the authorized person MUST also sign this line.
Printed Name of Person Submitting Enrollment	Enter the name of the authorized person completing the form.
Printed Title of Person Submitting Enrollment	Enter the title of the authorized person completing the form.
Submission Date	Enter the date, in MM/DD/CCYY format, on which the form is being submitted.