# Medicaid Application Center

# Electronic Funds Transfer (EFT) Enrollment Form

## (Instructions)

1. Facility Name: Enter the name in which you are currently enrolled as a Certified Medicaid Application Center (AC).

2. Application Center Identification Number: Enter the Application Center's AC ID number.

3. Contact Name: Enter the name of the person designated as the contact for AC electronic funds transfer (EFT) issues.

4. Contact Phone: Enter contact person's phone number.

5. Contact Fax: Enter contact person's fax number.

6. Contact E-mail: Enter contact person's e-mail address.

7. Account Type: Check the appropriate block (only one) to indicate the type of account in which your EFT will be deposited.

8. Reason for Change: If this is a new enrollment, leave this field blank. For a change to existing account information, give a brief description of why the EFT account information is being updated.

9. **Voided Check**: Tape a copy of a voided check showing the ABA routing number and account number. The check must have a preprinted business name and address. ***Deposit slips are not accepted. Counter checks are not accepted.*** If a voided check is unavailable, a letter on bank letterhead identifying the ABA routing number, account number and type of account may be substituted. The letter must be signed by a bank representative with his/her contact information.

**The name listed on the voided check must match the name on the Application Center Contractual Agreement.**

10. Printed Name and Signature, Title, Date: Print name and affix signature. Include the title of the person authorized to sign and enter the date the form was signed. Some organizations may require more than one signature. If additional space is needed for signatures, please attach additional sheets. **ORIGINAL SIGNATURES ONLY.**

Please be sure to complete this form in its entirety. If not, the form will not be accepted for processing and will be returned to you.

# Medicaid Application Center
# Electronic Funds Transfer (EFT) Enrollment Form

Please review instructions on page 1 before completing this form.

**Facility Name:** **AC ID #:**

**Name of Contact Person:** ______________________ **Contact Person Phone Number:** ______________________

**Contact Person Fax Number:** ______________________ **Contact Person E-mail Address:** ______________________

**Account Information**

**Account Type:** **(Check One)**
- ☐ Checking
- ☐ Savings

Reason for change in account information: ______________________

**Attach copy of voided check (deposit slips and counter checks are not acceptable).**

***Name on account must match name on the Application Center Contractual Agreement.***

TAPE COPY OF VOIDED CHECK HERE – NO STAPLES

DEPOSIT SLIPS ARE NOT ACCEPTED
COUNTER CHECKS ARE NOT ACCEPTED

***If a voided check is unavailable, you may submit a letter on bank letterhead stating the ABA routing number and account number. The letter must be signed by a bank representative.***

**The voided check must show the complete account number and ABA routing number.**
**The name on the account listed on the voided check must match the name on the facility's Contractual Agreement.**
**If a change of administration has occurred, a new Application Center Contractual Agreement is required.**

- I/We understand that DHH may revoke this authorization at any time.
- I/We certify that if a Board of Directors' approval was necessary to enter into this agreement approval has been obtained and the signature below is authorized by the stated Board of Directors to enter into this agreement.

**Original signature required—stamped signature or initials not acceptable.**

| Printed Name of Authorized Agent | Title | Date |
|---|---|---|
| Signature of Authorized Agent | | |

**BE SURE THAT ALL FIELDS ARE COMPLETED**

# Medicaid Application Center Program

**Facility Name:** **AC ID #**

## Medicaid Application Center Electronic Funds Transfer (EFT) Authorization Agreement

I have reviewed the Medicaid Application Center Electronic Funds Transfer (EFT) Enrollment Form and Instructions and agree to this agreement:

- I understand that payment and satisfaction of any claims will be from Federal and State Funds and any false service tickets, statements or documents, or concealment of a material fact may be prosecuted under applicable Federal and State laws.
- I understand that the Louisiana Department of Health and Hospitals (DHH) may revoke this authorization at any time.
- I hereby authorize DHH to present credit entries into the account and named depository referenced in the Medicaid Application Center Electronic Funds Transfer (EFT) Enrollment form. These credits pertain only to direct deposit transfer payments that the payee will have rendered for Medicaid Application Center services.
- I certify that, if a Board of Directors approval was necessary to enter into this agreement approval has been obtained and the signature(s) below is/are authorized by the stated Board of Directors to enter into or change this agreement.
- I agree to notify DHH staff at least 30 days in advance if changing financial institutions or accounts. Notice will be given by completing the Medicaid Application Center Electronic Funds (EFT) Enrollment form.
- I further understand that the maintenance of account information on the Medicaid Application Center files is the facility's responsibility and failure to notify the DHH staff as noted may result in application center payments being electronically transmitted to incorrect accounts or returned.

______________________________ ______________________________

**Printed Name of Authorized Agent** **Signature of Authorized Agent**

***Legal Note: This enrollment form confirms your desire to enroll in the EFT Payment Process.**

# Medicaid Application Center
# Update Information Form

**Facility Name:** **AC ID #:**

**Physical Address:** ______________________________________________

______________________________________________

**Zip Code:** _________________- _________*(Zip+4 requested)

**Mailing Address:** ______________________________________________

______________________________________________

**Zip Code:** _________________- _________*(Zip+4 requested)

**Contact Person (If different from contact for EFT issues):**

_________________________________________________________

**Phone Number:** _________________________________________

**Fax Number:** _________________________________

**Tax Identification Number:** ___ ___ - ___ ___ ___ ___ ___ ___ ___

**Please return completed forms to:**

**Application Center Program**
**DHH/MVA**
**P.O. Box 91278**
**Baton Rouge, LA 70821-9278**