MISSOURI DEPARTMENT OF SOCIAL SERVICES (DSS)
MISSOURI MEDICAID AUDIT AND COMPLIANCE (MMAC)
Electronic Funds Transfer (EFT) Authorization Agreement

SECTION 1 – PROVIDER INFORMATION	
LEGAL BUSINESS NAME:	DOING BUSINESS AS NAME:
PROVIDER EIN:	PROVIDER NPI:
ARE THERE MULTIPLE ENROLLMENTS UNDER THIS EIN OR NPI? ***A separate form must be submitted for each NPI/taxonomy code to be changed.*** NO ☐ YES ☐ ***- taxonomy codes effected:***	
SECTION 2 – PROVIDER CONTACT INFORMATION	
CONTACT PERSON NAME:	
PHONE NUMBER:	E-MAIL ADDRESS:
SECTION 3 – FINANCIAL INFORMATION	
FINANCIAL INSTITUTION NAME:	
ROUTING NUMBER:	ACCOUNT NUMBER:
TYPE OF ACCOUNT: ☐ CHECKING ☐ SAVINGS	
SECTION 4 – SUBMISSION INFORMATION	
REASON FOR SUBMISSION: ☐ NEW ENROLLMENT – NOT ENROLLED CURRENTLY ☐ CHANGE/UPDATE EFT ONLY ☐ CHANGE IN OWNERSHIP / STRUCTURE – ***SUBMIT A PROVIDER UPDATE FORM OR OWNERSHIP REQUEST IN ADDITION TO THIS DOCUMENT***	
TYPE OF SUPPORTING DOCUMENT BEING SUBMITTED WITH THIS FORM: ☐ VOIDED CHECK WITH LEGAL OR DBA NAME, ROUTING AND ACCOUNT NUMBERS PREPRINTED ON IT ☐ BANK LETTER THAT LISTS LEGAL OR DBA NAME, ROUTING AND ACCOUNT NUMBERS	
SECTION 5 – SIGNATURE AND ACKNOWLEDGEMENT	
By completing and submitting this form to the Missouri Medicaid Audit and Compliance Unit (MMAC) for processing, I understand: 1. **Payment will be from Federal and State funds and that any falsification or concealment of material fact may be prosecuted under Federal and State laws;** 2. **The State of Missouri will initiate credit entries (deposits) and will initiate, if necessary, debit entries (withdrawals) or adjustments for any credit entries made in error to my account;** 3. **The State of Missouri may terminate my enrollment in direct deposit if the State is legally obligated to withhold part or all payments for any reason;** 4. **MMAC may terminate my enrollment if I no longer meet the eligibility requirements;** 5. **That this document does not constitute an amendment or assignment of any nature whatsoever of any contract, purchase order or obligation that I may have with any agency of the State of Missouri**.	
WRITTEN SIGNATURE OF AUTHORIZED INDIVIDUAL	DATE:
PRINTED NAME OF SIGNER:	POSITION HELD WITHIN THE ENTITY NAMED ABOVE:
MMAC USE ONLY BELOW THIS LINE	
☐ APPROVED ☐ REJECTED	
COMMENTS BY MMAC STAFF:	
REVIEWED BY:	DATE:
IF APPLICABLE - KEYED BY:	DATE:

This form complies with the CORE 380 EFT Enrollment Data Rule version 3.0.0 dated June 2012 mandated requirements.

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Electronic Funds Transfer (EFT) Authorization Agreement

Electronic Funds Transfer (EFT) Authorization Agreement Instructions

Automated clearing house (ACH) accounts only, wire transfer is not available.

Type or print in black ink.

A separate form must be submitted for <u>each</u> NPI/taxonomy code to be changed.

Contact your financial institution to arrange for the delivery of CORE-required Minimum CCD+ Data Elements necessary for successful reassociation of the EFT payment with the ERA remittance advice.

To resolve a late or missing 835, contact the Wipro Technical Help Desk at (573) 635-3559.

If you are inquiring about a missing or late EFT payment, you must contact your financial institution.

SECTION 1: PROVIDER INFORMATION	
Provider Name	Complete legal name of institution, corporate entity, practice or individual provider.
Doing Business as Name (DBA)	A legal term used in the United States meaning that the trade name, or fictitious business name, under which the business or operation is conducted and presented to the world is not the legal name of the legal person (or persons) who actually own it and are responsible for it.
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	A Federal Tax Identification Number, also known as the Employer Identification Number (EIN), is used to identify a business entity.
National Provider Identifier (NPI)	The NPI is a unique identification number for covered healthcare providers.
Are there multiple enrollments under this EIN or NPI?	A separate form must be submitted for each NPI/taxonomy code to be changed. If there are multiple enrollments under this EIN or NPI, please submit one EFT Agreement per provider type. EX: NPI 1234567891 has a clinic and a rural health clinic under the NPI provided, list the taxonomy code being updated.
SECTION 2: PROVIDER CONTACT INFORMATION	
Provider Contact Name	Name of a contact in provider office for handling EFT issues.
Telephone Number	Telephone number associated with contact person.
Email Address	An electronic mail address at which the health plan might contact the provider.
SECTION 3 – FINANCIAL INFORMATION	
Financial Institution Name	Official name of the provider's financial institution.
Financial Institution Routing Number	A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited. Enter the number twice for validation.
SECTION 4 – SUBMISSION INFORMATION	
Reason for Submission*	New Enrollment – not enrolled – **submit with an application** Change/Update EFT ONLY – no other changes Change of Ownership/Structure change – **submit with Update Request or HCBS Ownership Request**
Include with Enrollment Submission	Voided Check: A voided check is attached to provide confirmation of Identification/Account Numbers. Bank Letter: A letter on bank letterhead that formally certifies the account owners and account numbers.
Position Held with Entity Named Above	Verify the position held by the signer of the form.
Written Signature of Individual Authorized by Provider or its Agent to Initiate, Modify or Terminate Enrollment*	A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorizations and identity.
Printed Name of Person Submitting*	The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment.
Submission Date*	The date on which the enrollment is submitted.

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