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

By completing and submitting this form to the Missouri Medicaid Audit and Compliance Unit (MMAC) for processing, I understand

- 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;
- 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;
- 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;
- MMAC may terminate my enrollment if I no longer meet the eligibility requirements; and
- 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.

SECTION I: PROVIDER INFORMATION

PROVIDER NAME*

DOING BUSINESS AS NAME (DBA)

SECTION II: PROVIDER ADDRESS

STREET*	CITY*	STATE /PROVINCE*	ZIP CODE/POSTAL CODE*

SECTION III: PROVIDER IDENTIFIERS INFORMATION

PROVIDER FEDERAL TAX IDENTIFICATION NUMBER (TIN) OR EMPLOYER IDENTIFICATION NUMBER (EIN)*

NATIONAL PROVIDER IDENTIFIER (NPI)*	PROVIDER TAXONOMY CODE

SECTION IV: PROVIDER CONTACT INFORMATION

PROVIDER CONTACT NAME*

TELEPHONE NUMBER* ext.	EMAIL ADDRESS

SECTION V: FINANCIAL INSTITUTION INFORMATION

FINANCIAL INSTITUTION NAME*

FINANCIAL INSTITUTION ROUTING NUMBER*	FINANCIAL INSTITUTION ROUTING NUMBER*
PROVIDER'S ACCOUNT NUMBER WITH FINANCIAL INSTITUTION*	PROVIDER'S ACCOUNT NUMBER WITH FINANCIAL INSTITUTION*

TYPE OF ACCOUNT AT FINANCIAL INSTITUTION*

☐ CHECKING ☐ SAVING

ACCOUNT NUMBER LINKAGE TO PROVIDER IDENTIFIER (SELECT ONE AND FILL IN THE NUMBER)*

☐ PROVIDER TAX IDENTIFICATION NUMBER (TIN): _____

☐ NATIONAL PROVIDER IDENTIFIER (NPI): _____

SECTION VI: SUBMISSION INFORMATION

REASON FOR SUBMISSION*

☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

INCLUDE WITH ENROLLMENT SUBMISSION*

☐ Voided Check
☐ Bank Letter

WRITTEN SIGNATURE OF INDIVIDUAL AUTHORIZED BY PROVIDER OR ITS AGENT TO INITIATE, MODIFY OR TERMINATE ENROLLMENT*	PRINTED NAME OF PERSON SUBMITTING*	SUBMISSION DATE*

MMAC Provider Enrollment
P.O. Box 6500 (mailing), 205 Jefferson St., 2nd Fl (physical)
Jefferson City, MO 65102
Fax: 573/751-5065
e-mail: mmac.providerenrollment@dss.mo.gov

MISSOURI MEDICAID AUDIT AND COMPLIANCE USE ONLY

PROCESSED BY:	DATE:

12/2013

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

Electronic Funds Transfer (EFT) Authorization Agreement Instructions

Automated clearing house (ACH) accounts only, wire transfer is not available. Type or print in black ink.
All required information indicated by * must be completed. A separate form must be submitted for each NPI/taxonomy code to be changed.
To update payee information, complete an Update Request form available at http://mmac.mo.gov/providers/provider-enrollment.
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 I: 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.
SECTION II: PROVIDER ADDRESS	
Street*	The number and street name where a person or organization can be found.
City*	City associated with provider address field.
State/Province*	Character code associated with the State/Province/Region of the applicable Country.
Zip Code/Postal Code*	System of postal-zone codes (zip stands for “zone improvement plan”) introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities.
SECTION III: PROVIDER IDENTIFIERS INFORMATION	
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)*	A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.
Provider Taxonomy Code	A unique alphanumeric code, ten characters in length. The code set is structured into three distinct "Levels" including Provider Type, Classification and Area of Specialization.
SECTION IV: 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 V: FINANCIAL INSTITUTION 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.
Provider’s Account Number With Financial Institution*	Provider’s account number at the financial institution to which EFT payments are to be deposited. Enter the number twice for validation.
Type of Account at Financial Institution*	Check the type of account funds are to be deposited to. Enter the number twice for validation.
Account Number Linkage to Provider Identifier (Select one and Fill in the Number)	Provider preference for grouping (bulking) claim payments – much match preference for v5010X12835 remittance advice. NOTE: EFT data will always be linked by the MO HealthNet trading partner ID related to the NPI/taxonomy.
SECTION VI: SUBMISSION INFORMATION	
Reason for Submission*	New Enrollment, Change Enrollment, Cancel Enrollment.
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.
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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