Division of Medical Services
Gainwell Technologies Provider Enrollment Unit
P.O. Box 8105, Little Rock, AR 72203-8105
P: (501) 376-2211 WATS: (800) 457-4454

Authorization for Electronic Funds Transfer (Automatic Deposit)

Dear Provider:

Provider Enrollment will no longer accept provider enrollment applications without a completed authorization for **Electronic Funds Transfer (EFT**) form for all enrolling facilities and individual providers not eligible for section IV group linkage. Providers must utilize EFT, which allows your Medicaid payments to be directly deposited into your bank account. In addition to providing more secure payment and decreased administrative costs, you will notice a difference in your cash flow with EFT because it makes your money available sooner than the actual clearance date of paper checks. Arkansas Medicaid appreciates your cooperation in allowing us to be more efficient and environmentally friendly.

When enrolling as a Medicaid provider, you **must** complete the Authorization for Electronic Funds Transfer form AND attach a voided check or a letter from the bank that includes

- Account holder's name
- Bank account number (ABA)
- Routing number

Payments will be made to the provider Medicaid ID listed as the "billing provider" on a claim. If billing under a group billing Medicaid ID as a "rendering provider;" claim payments will always be paid to the biller's Medicaid ID and the bank account registered to the group's Medicaid enrollment.

Managed Care Payments: PCCM payments are paid to the Medicaid ID listed on their PCP agreement.

Voided Check Requirements: If submitting a voided check, the name printed on the check must match the enrolling provider's name submitted on their application. We recommend:

- Individual providers: submit EFT information that will direct payment to the provider's personal checking account matching their enrolling name.
- Providers linked to a group: submit EFT information with their group's banking information registered in the business/facilities name and a bank letter.

Bank Letter Requirements: If a bank letter is required, it must include

- Account holder's name
  The account holder's name must match the provider's name **or** indicate the provider has depositing rights into the account.
- Bank account number (ABA)
- Routing number
- Authorized bank employee's signature

Provider Enrollment will no longer accept faxed copies of this form or attachments. EFT changes and attachments can be submitted through provider portal (preferred) or mailed to the address at the bottom of the EFT form.

Requests to update EFT information will be verified by a provider enrollment analyst. Before processing any EFT changes (except new enrollments), the provider will be called at the phone number on file for their Medicaid ID only. The Enrollment Analyst will ask to confirm the change was requested.

If you have any further questions concerning this letter, please contact the Provider Assistance Center locally at (501) 376-2211 or (800) 457-4454 toll free.

Sincerely,
Arkansas Department of Human Services

Authorization for Electronic Funds Transfer
(Automatic Deposit)

Name of Medicaid Provider _____

Provider Medicaid ID # _____ (Enter "pending" for new enrollment)

Type of Authorization ☐ New ☐ Change ☐ Cancel

A copy of a **voided check** or a **letter from the bank** is required to verify these numbers. The name on the voided check or letter from bank **must match the name of the Medicaid provider stated above.** Temporary checks are **not** accepted.

☐ Checking ☐ Savings (if not indicated, this will **automatically be entered as "checking."**)

_____ _____
ABA Transit Number Bank Account Number

_____
Name of Bank

I hereby authorize the Arkansas Medicaid Program/Title XIX, to initiate credit entries to my bank account as indicated above and the depository named above to credit the same to such account. I understand I am responsible for the validity on this form.

I understand in endorsing or depositing this check that payment will be from Federal and State funds and that any falsification or concealment of a material fact, may be prosecuted under Federal and State laws.

_____ _____
Printed name Job title

_____
Provider's Original Signature (required)

Submit EFT changes through the portal or mail this form and attachments to:

Medicaid Provider Enrollment Unit
Gainwell Technologies
P.O. Box 8105
Little Rock, AR 72203-8105