

UTAH MEDICAID

Electronic Funds Transfer (EFT) Enrollment and Authorization Agreement

PROVIDER INFORMATION (Data Element Group 1)

*Provider Name

Doing Business As Name (DBA) Optional

Provider Address

*Street

*City

*State/Province

*Zip Code/Postal Code

Country Code

PROVIDER IDENTIFIERS INFORMATION (Data Element Group 2)

*Provider Identifiers

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

*National Provider Identifier (NPI)

Other Identifiers

*Assigning Authority

Trading Partner ID

Provider License Number

Provider License Number

*License Issuer

Provider Type

e.g., hospital, laboratory, physician, pharmacy, pharmacist, etc.

Provider Taxonomy Code

PROVIDER CONTACT INFORMATION (Data Element Group 3)

*Provider Contact Name

Title

*Telephone Number

Telephone Number Extension

*Email Address

Fax Number

**PROVIDER AGENT INFORMATION
(Data Element Group 4)**

***Provider Agent Name**

Agent Address

*Street

*City

*State/Province

*Zip Code/Postal Code

Country Code

Provider Agent Contact

***Provider Agent Contact Name**

Title

*Telephone Number

Telephone Number Extension

Email Address

Fax Number

**FEDERAL AGENCY INFORMATION
(Data Element Group 5)**

Federal Agency Information

Federal Program Agency Name

Federal Program Agency Identifier

Federal Agency Location Code

**RETAIL PHARMACY INFORMATION
(Data Element Group 6)**

***Pharmacy Name**

Chain Number

Payment Organization ID

Payment Center ID

NCPDP Provider ID Number

NCPDP-assigned unique identification number

Medicaid Provider Number

FINANCIAL INSTITUTION INFORMATION
(Data Element Group7)

***Financial Institution Name**

Financial Institution Address

*Street

*City

*State/Province

*Zip Code/Postal Code

Financial Institution Telephone Number

Telephone Number Extension

***Financial Institution Routing Number:**

9-digit identifier of Financial Institution

***Type of Account at Financial Institution:**

Checking

Savings

***Provider's Account Number with Financial Institution:**

***Account Number Linkage to Provider Identifier**

Provider Tax Identification Number (TIN)

National Provider Identifier (NPI)

SUBMISSION INFORMATION
(Data Element Group 8)

***Reason for Submission**

New Enrollment

Change Enrollment

Cancel Enrollment

Include with Enrollment Submission

Voided Check

Bank Letter

***Authorized Signature**

Electronic Signature of Person
Submitting Enrollment

Written Signature of Person
Submitting Enrollment

Printed Name of Person Submitting Enrollment

Printed Title of Person Submitting Enrollment

Submission Date
(CCYYMMDD)

Requested EFT Start/Change/Cancel Date
(CCYYMMDD)

AUTHORIZATION FOR SETUP

I hereby authorize the State of Utah ("the State") to initiate credit entries to the account number listed above ("this account"). I further authorize the State to correct credit entries made in error to this account. I agree that this AUTHORIZATION FOR SETUP is to remain in full force and effect until the State has received written notification from me of its termination, in such time and manner as to afford the State and the Financial Institution a reasonable opportunity to act upon my notification. I recognize that if I fail to provide complete or accurate information on the above DIRECT DEPOSIT AUTHORIZATION FORM FOR ELECTRONIC FUNDS TRANSFERS (EFT) FOR MEDICAID PROVIDERS ("this form"), the processing of this form may be delayed and/or my payments may be erroneously transferred. In the event that funds are erroneously transferred due to my failure to provide complete or accurate information on this form, I hereby hold the State harmless for the recovery of such erroneous transfers, notwithstanding any reasonable attempts made by the State to correct such errors. I understand 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.

I, the undersigned certify that I am authorized to provide the above information and the information is true and correct.

****Authorized Signature***

****Date***

****Telephone Number***

For questions or status, call Provider Enrollment at 801-538-6155 or 1-800-662-9651, option 3, option 4.

Return form to:

**Bureau of Medicaid Operations
PO Box 143106
Salt Lake City, UT 84114-3106**

Fax: 1-801-536-0471

Email: providerenroll@utah.gov

Web address: <http://health.utah.gov/medicaid/>