Montana Medicaid

Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Authorization Agreement

The following information is confidential and is needed to prove entitlement to payments. The information will be used to process payment data from the payer to the financial institution and/or its agent. Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the Electronic Funds Transfer Program.

Please make arrangements with the financial institution receiving the EFT to ensure proper delivery of payments for services provided.

All fields on this form are **required** in order to enroll in electronic funds transfer and to ensure proper delivery of your electronic remittance advice.

If you have any questions about this form, contact Xerox Provider Relations at 1.800.624.3958 (In/Out of State) or 406.442.1837 (Helena).

DATA ELEMENT GROUP #1 – PROVIDER INFORMATION

Provider Name _____
(to include legal name of institution, corporate entity, practice, or individual provider)

Provider Address

Street _____

City _____

State/Province _____ ZIP Code/Postal Code _____

DATA ELEMENT GROUP #2 – PROVIDER IDENTIFIERS INFORMATION

Provider Identifiers

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

_____

National Provider Identifier (NPI)

_____

Trading Partner ID

_____

DATA ELEMENT GROUP #7 – FINANCIAL INSTITUTION INFORMATION

Financial Institution Name _____

Financial Institution Routing Number _____

Type of Account at Financial Institution _____
(The type of account provider will use to receive EFT payments, e.g., checking, savings)

Provider's Account Number with Financial Institution _____

Account Number Linkage to Provider Identifier. Select one from below.

Provider Tax Identification Number ☐

National Provider Identifier ☐

(Provider preference for grouping [bulking] claim payments – must match preference for v5010 X12 835 remittance advice.)

Preference for Aggregation of Remittance Data, e.g., account number linkage to provider identifier. Select one from below.

Provider Tax Identification Number ☐

National Provider Identifier ☐

DATA ELEMENT GROUP #8 – SUBMISSION INFORMATION

Reason for Submission

☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

Authorized Signature

Written Signature of the Person Submitting Enrollment

Printed Name of Person Submitting Enrollment

Title of Person Submitting Enrollment

Submission Date _____ / _____ / _____

Requested Effective Date _____ / _____ / _____