



**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 Conduent 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

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Printed Name of Person Submitting Enrollment

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Title of Person Submitting Enrollment

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Submission Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Requested Effective Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_