Montana Medicaid

Electronic Funds Transfer (EFT)

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.

Any changes to EFT banking information will require verbal authorization. After submission of this form, the Owner, Authorized Representative or Manager (as listed on the enrollment record) will be contacted for verbal authorization prior to the completion of any requested changes.

If you have any questions about this form, contact Conduent Provider Relations at (800) 624-3958 (In/Out of State) or (406) 442-1837 (Helena).

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

Provider Address:_____

_____

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

_____

National Provider Identifier (NPI), Atypical Number, or Passport Number:

_____

Information Required	Current Account Information (Required if you are an existing provider with banking information currently on file with Montana Healthcare Programs)	New Account
Financial Institution Name		
Type of Account (checking, savings)		
Financial Institution Routing Number		
Provider's Account Number		

Reason for Submission: _____**New Enrollment** _____**Change EFT**

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I, _____hereby certify that the account indicated on this form is under my direct control and access; therefore, I authorize Conduent as fiscal agent for the State of Montana to make the changes indicated below.

This authority is to remain in full force and effect until the State of Montana has received written notification from either me or an authorized officer of the organization of the account's termination in such time and in such a manner as to afford the State of Montana a reasonable opportunity to act upon it.

Written Authorized Signature of Person Submitting This Form:

_____

Submission Date:

_____

Title of Person Submitting This Form:

_____

Requested Effective Date:

_____

When complete, fax this form to: (406) 442-4402 or (888) 772-2341 or
Mail To: Provider Relations, PO Box 4936, Helena, MT 59604