Montana Healthcare Programs
Electronic Funds Transfer 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 (EFT) 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** 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. **There is a hold on deposits of $10,000 or more due to a banking change or an initial EFT payment to a provider.**

If you have any questions about this form, contact 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
Include street address, city, state and ZIP+4. A post office box address is not acceptable.

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

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

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Complete the table below. Current account information is required if you are an existing provider with banking information currently on file with Montana Healthcare Programs.

When asked to provide EFT information **not** related to a new enrollment or change in EFT, select the Providing Current Information option below, indicate the reason, and provide current account information in the table.

Reason for Submission

☐ New Enrollment

☐ Change EFT

☐ Providing Current Information

Reason for providing _____

Information Required	Current Account Information	New Account
Financial Institution Name		
Type of Account (Checking, Savings)		
Financial Institution Routing Number		
Provider's Account Number		

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.

Authorized Signature of Person Submitting This Form **Submission Date**

_____ _____

Title of Person Submitting This Form **Requested Effective Date**

_____ _____

Attach the completed form online to your updated enrollment or mail this form to Provider Services, P.O. Box 89, Great Falls, MT 59403.