Louisiana Medicaid Program

LOUISIANA MEDICAID DIRECT DEPOSIT (EFT) AUTHORIZATION AGREEMENT FOR PROVIDERS

(Form is subject to change without notice)
GENERAL INFORMATION FOR THE DIRECT DEPOSIT (EFT) AUTHORIZATION AGREEMENT

Individual providers:

Individual providers must sign their own forms.

Original signatures only; no stamps or copied signatures will be accepted. (Blue or colored ink preferred – not black ink).

If the individual provider is doing group billing only, then an EFT form should not be completed for the individual. Instead, an EFT form should be submitted (or already on file) only for the business or entity which the individual is linked to.

Business/Entity providers:

Only an authorized representative may sign this form. This authorized representative must be someone designated to enter into a legal and binding contract with Louisiana Medicaid. This person must be someone currently listed on the Disclosure of Ownership as either an owner or manager. Any other signature will be grounds for rejecting this form.

Original signatures only; no stamps or copied signatures will be accepted. (Blue or colored ink preferred – not black ink).

The provider name on this form must match the provider name associated with the Louisiana Medicaid number, the NPI, or both.

If the entity/business is doing group billing, then an EFT form is required for the group only, and not the individual providers.

Send your completed EFT Form to:

Molina Provider Enrollment Unit
P.O. Box 80159
Baton Rouge, LA 70898-0159

Call Molina Provider Enrollment at (225) 216-6370 if you have questions regarding the completion of this form or the status of your request. You may also go to lamedicaid.com under the Provider Enrollment link for Provider Enrollment contact information.

Once you are enrolled for EFT and your electronic payments are missing or late, first contact the Automated Clearinghouse (ACH) representative at your bank, not a bank teller. If the bank is unable to locate the deposit, check to ensure that the account has not been closed or changed. Finally, if still unable to locate a deposit, call Molina Provider Enrollment at (225) 216-6370 and report the late and/or missing EFT transaction.

Once enrolled for EFT and if you choose to receive your remittance advice data in the V5010x12 835 transaction, then you may wish to contact your financial institution in order to arrange for delivery of the CORE-required minimum CCD+ data elements needed for re-association of the payment and the 835 Electronic Remittance Advice.
# LOUISIANA MEDICAID DIRECT DEPOSIT (EFT) AUTHORIZATION AGREEMENT

## INSTRUCTIONS

1. **Provider Name**
   - Complete legal name of institution, corporate entity, practice or individual provider.

2. **DBA Name**
   - The name by which the provider is conducting business.

3. **Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)**
   - A Federal Tax Identification Number, also known as an Employer Identification Number (EIN) is used to identify a business entity (9 digits).

4. **National Provider Identifier (NPI)**
   - A Health Insurance Portability and Accountability Act (HIPAA) identification number.
   - Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number).
   - This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

5. **Molina Medicaid Trading Partner ID (7 digits)**
   - The provider's 7-digit Louisiana Medicaid identification number.

6. **Provider Contact Name**
   - Name of a contact in provider office for handling EFT issues.

7. **Telephone Number**
   - Associated with contact person.

8. **Email Address**
   - An electronic mail address at which the health plan might contact the provider.

9. **Financial Institution Name**
   - Official name of the provider's financial institution.

10. **Financial Institution Routing Number**
    - A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited.

11. **Type of Account at Financial Institution**
    - The type of account the provider will use to receive EFT payments, e.g., Checking, Saving (check the appropriate box).

12. **Provider Account Number with Financial Institution**
    - Provider's account number at the financial institution to which EFT payments are to be deposited (up to 10 digits).

13. **Account Number Linkage to Provider Identifier**
    - Check one: Provider Tax Identification Number (TIN), or National Provider Identifier (NPI).

14. **Reason for submission**
    - Check one: New Enrollment, Change Enrollment, or Cancel Enrollment

15. **Voided Check**
    - A voided check is attached to provide confirmation of Identification/Account Numbers.

16. **Written Signature of Person Submitting Enrollment**
    - A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity.

17. **Printed Name of Person Submitting**
    - The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment.

18. **Printed Title of Person Submitting Enrollment**
    - The printed title of the person signing the form.

19. **Submission Date**
    - CCYYMMDD
DEPARTMENT OF HEALTH AND HOSPITALS
LOUISIANA MEDICAID DIRECT DEPOSIT (EFT) AUTHORIZATION AGREEMENT

1. Provider Name

2. Doing Business As (DBA) Name

3. Provider TIN or EIN (9 digits)

4. National Provider Identifier (NPI) (10 digits)

5. Molina Medicaid Trading Partner ID (7 digits)

6. Provider Contact Name

7. Provider Contact Telephone Number

8. Provider Contact Email Address

9. Financial Institution Name

10. Financial Institution Routing Number (9 digits)

11. Type of Account at Financial Institution (check one)

   - CHECKING
   - SAVINGS

12. Provider Account Number with Financial Institution

13. Account Number Linkage to Provider Identifier (check one)

   - Provider Tax Identification Number (TIN)
   - National Provider Identifier (NPI)

14. Reason for Submission (check one)

   - New Enrollment
   - Change Enrollment
   - Cancel Enrollment

15. Attach Copy of Voided Check Here (Deposit Slips are not Acceptable)

   I understand that payment and satisfaction of this claim will be from Federal and State Funds and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal and State laws. I understand that DHH may revoke this authorization at any time.

   I hereby authorize the Louisiana Department of Health and Hospitals to present credit entries into the account and depository named above. These credits will pertain only to direct deposit transfer payments that the payee receives from Medicaid.

   I certify that if a Board of Directors' approval is necessary to enter into this agreement, that approval has been obtained and the signature below has been authorized by the stated Board of Directors to enter into this agreement.

   I agree to notify the Provider Enrollment Unit if changing financial institutions or accounts. I further understand that the maintenance of account information on the Louisiana Medicaid files is the provider’s responsibility and failure to notify the Provider Enrollment Unit may result in Medicaid payments being electronically transmitted to incorrect accounts. I understand that such changes may not be accommodated if less than a 15 business day notice is given.

   Only an authorized representative may sign this form. This authorized representative must be someone designated to enter into a legal and binding contract with Louisiana Medicaid on behalf of the provider.

16. Written Signature of Person Submitting Enrollment
   (Authorized Signature)

17. Printed Name of Person Submitting Enrollment

18. Printed Title of Person Submitting Enrollment

19. Submission Date
Addendum to the
LOUISIANA MEDICAID DIRECT DEPOSIT (EFT) AUTHORIZATION AGREEMENT

A. If the Reason for Submission is “Change Enrollment,” specify the reason:
   - ☐ Change of Ownership
   - ☐ Change of Bank or Financial Institution
   - ☐ Other
   If Other, please specify: __________________________________________________

NOTE: If a change of ownership (CHOW) occurs, an entire enrollment packet is required and direct deposit information cannot be changed for the current provider account.

B. Is the bank account you specified located in the United States?
   - ☐ Yes
   - ☐ No
   Of No, please identify the country of location: ________________________________

NOTE: If the specified bank account is not in the United States, Molina Provider Enrollment will reject this request due to Medicaid funds not being allowed to be deposited into out of country accounts.