



**ELECTRONIC FUNDS TRANSFER (EFT)
FORM**

Complete all fields on this form and attach a voided check or one of your bank deposit slips. The ABA transit routing number can be obtained from your bank.

Does the bank account listed below belong to a billing agency? Yes No

Provider Name _____ Provider Number _____

Provider Tax ID Number _____ ABA Transit Routing Number _____

Bank Name _____

Bank Address _____

Bank Account Number _____ Bank Account Name _____

Tax ID Number of Account Holder _____

Bank Telephone Number _____ - _____ Checking Savings

Type of Authorization Start Cancel Change

Is the change due to a change of ownership? Yes No

The following documents must be included with this form:

- **A voided check or a deposit slip**
- **A copy of a bank statement or other bank form displaying the tax ID on the bank account**

On behalf of the provider entity named above, I agree to keep, and disclose upon request to authorized agencies, records that fully disclose the extent of claim payments received from and services rendered to members of the Indiana Health Coverage Programs (IHCP). I accept as payment in full the amount paid by the IHCP for claims submitted with the exception of authorized cost sharing by members. I understand payment of IHCP claims is from state and federal funds and that any false claims, statements, documents or concealment of a material fact may be prosecuted under state or federal law. I ensure that this EFT request complies with the regulation set forth in 42 CFR 447.10, which prohibits State payments for any IHCP service to be made to anyone other than a Provider, a non-cash member, or to one of the listed exceptions. I understand that an IHCP payment may be sent via EFT to an account held by the following only: (1) to the Provider; (2) a non-cash member; (3) a government agency on reassignment by the Provider (IRS); (4) a third party by court order on reassignment by the Provider (child support); (5) a business agent (billing service, account firm) if three specific criteria are met (see page 2*); (6) the employer of the Practitioner (if a contract so requires); (7) a health care facility, or a health care delivery system (if a contract so requires) if the organization itself submits the claim directly to the IHCP.

I authorize the electronic transfer of IHCP payments (including 590, Medicaid and Package C) made to the above provider number. I understand that I am responsible for the validity of the above information. I agree to notify EDS within ten (10) days of any change in any of the information included on this form.

This section must be completed by an authorized officer or owner of the billing provider.

Printed Name & Title	Telephone Number
Signature	Date

Note: It will take approximately four weeks for this information to be processed by EDS and validated by your bank. Please send this form to the address listed in the bottom left corner of this form.

This section must be completed if a billing agent is receiving payment on behalf of the provider.

**The exception for a business agent is limited to agents who furnish statements and receive payments in the name of the provider, and the service provided by the agent is: (1) related to the cost of processing the bill; (2) not related to a percentage or other basis to the amount billed or collected; and (3) not dependent upon the collection of payment. Further, a payment for a provider may not be made to or through an individual or organization (collection agency or service bureau), or by power of attorney thereof, that advances money for accounts receivable that a provider has assigned, sold, or transferred to the organization for a fee or deduction of accounts receivable.*

If the EFT for the provider named on this document will be sent to a bank account belonging to a billing agent and not the bank account of the provider, you must complete the section below.

Billing Agent Name	Telephone Number	Billing Agent's Tax ID
Billing Agent Address		
Authorized Billing Agent Contact Name	Title	
Authorized Billing Agent Signature	Date	