LOUISIANA DEPARTMENT OF HEALTH (LDH)
LOUISIANA MEDICAID DIRECT DEPOSIT (EFT) AUTHORIZATION AGREEMENT

1. Provider Name _____

2. Doing Business As (DBA) Name _____

3. Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) (9 digits) | | | | | | | | | |

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

5. Louisiana Medicaid Provider Number (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. Is the bank account you specified located in the United States? ☐ Yes ☐ No
If no, identify the country of location: _____

14. Account Number Linkage to Provider Identifier (check one) ☐ Provider Tax Identification Number (TIN) ☐ National Provider Identifier (NPI)

15. Reason for Submitting this form ☐ New Enrollment ☐ CHOW ☐ Re-validation of Existing Enrollment
Re-enrollment ☐ Other _____

16. Attach a voided check with this document for verification of financial institution account and routing number. **Deposit slips are not accepted.**

- The provider understands 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.
- **The provider understands that LDH may revoke this authorization at any time.**
- The provider hereby authorizes the Louisiana Department of Health 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.
- The provider certifies 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.
- The provider agrees to notify the Provider Enrollment Unit if changing financial institutions or accounts and understands that the maintenance of account information on the Louisiana Medicaid files is the provider's responsibility. Failure to notify the Provider Enrollment Unit may result in Medicaid payments being electronically transmitted to incorrect accounts. The provider understands 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.

17. Signature of Authorized Representative _____

18. Print Name of Authorized Representative _____

19. Print Title of Authorized Representative _____

20. Date of Signature (MM/DD/YYYY) _____