

Louisiana Medicaid Program

Louisiana Medicaid Direct Deposit (EFT) Authorization Agreement For Individual Providers

(Enrollment packet is subject to change without notice)

**LOUISIANA DEPARTMENT OF HEALTH (LDH)
LOUISIANA MEDICAID DIRECT DEPOSIT ELECTRONIC FUNDS TRANSFER (EFT)
AUTHORIZATION AGREEMENT**

GENERAL INFORMATION

Instructions for Completion:

- Individual providers must sign their own forms.
- Original signatures only; no stamps or copied signatures will be accepted. (Blue 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.
- Call Gainwell Provider Enrollment at (225) 216-6370 if you have questions regarding the completion of this form or the status of your request.

Late or Missing EFT Payments:

- 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.
- If still unable to locate a deposit, call Gainwell Provider Enrollment and report the late and/or missing EFT transaction.

Remittance Advice Data

- If you sign up for EFT and also receive your remittance advice data in the v501x12 835 transaction (ERA), you must contact your financial institution if you wish to arrange for delivery of the CORE-required Minimum CCD+ data elements needed for re-association of the payment and the ERA.

Send your completed EFT Form to:

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

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INSTRUCTIONS

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| 1. Provider Name | Complete legal name of institution, corporate entity, practice or individual provider. |
| 2. Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) | A Federal Tax Identification Number (TIN), also known as an Employer Identification Number (EIN) is used to identify a business entity (9 digits). |
| 3. 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. |
| 4. Louisiana Medicaid Provider Number (7 digits) | The provider's 7-digit Louisiana Medicaid provider number. |
| 5. Provider Contact Name | Name of a contact in the provider office for handling EFT issues. |
| 6. Provider Contact Telephone Number | The telephone number associated with the Provider Contact Name. |
| 7. Provider Contact Email Address | An electronic mail address at which the health plan might contact the provider. |
| 8. Financial Institution Name | The official name of the provider's financial institution. |
| 9. 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. |
| 10. Type of Account at Financial Institution | The type of account the provider will use to receive EFT payments, e.g., Checking, Savings (check the appropriate box). |
| 11. 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). |
| 12. Is the bank account you specified located in the United States? | Check yes or no. If no, please provide the country of location of the account. |
| 13. Account Number Linkage to Provider Identifier | Check one: Provider Tax Identification Number (TIN), or National Provider Identifier (NPI). |
| 14. Reason for Submitting this form | Indicate the reason for submission of the form: New Enrollment, Change Enrollment, Cancel Enrollment or Other |
| 15. Voided Check | Attach a voided check for verification of financial institution account and routing number.
Deposit slips are not accepted. |
| 16. Signature of Individual Provider | Signature of individual provider in blue ink. |
| 17. Printed Name of Individual Provider | The printed name of the individual provider. |
| 18. Date of Signature | The date the form is completed; Desired format: CCYYMMDD |

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LOUISIANA MEDICAID DIRECT DEPOSIT (EFT) AUTHORIZATION AGREEMENT

1. Provider Name _____

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

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

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4. Louisiana Medicaid Provider Number (7 digits)

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5. Provider Contact Name _____

6. Provider Contact Telephone Number _____

7. Provider Contact Email Address _____

8. Financial Institution Name _____

9. Financial Institution Routing Number (9 digits)

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10. Type of Account at Financial Institution (check one) ☐ CHECKING ☐ SAVINGS

11. Provider Account Number with Financial Institution

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12. Is the bank account you specified located in the United States? ☐ YES ☐ NO

If no, identify the country of location: _____

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

14. Reason for Submitting this form: ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

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

- 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 LDH may revoke this authorization at any time.**
- I hereby authorize 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.
- 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. Signature of Individual Provider _____

17. Printed Name of Individual Provider _____

18. Date of Signature _____