

Florida Medicaid Electronic Funds Transfer (EFT) Authorization Agreement

Provider Information*

Provider Name*		
Doing Business As Name (D/B/A)		
Provider Address Street * <i>(Street Name and Number – NOT a P.O. Box)</i>		
Provider Address <i>(Suite, Room, etc.)</i>		
City*	State*	ZIP*

Provider Identifiers Information*

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)*	National Provider Identifier (NPI)^
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Other Identifiers* Assigning Authority - Florida Medicaid

Provider Identification Number*	Trading Partner ID^
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Provider Contact Information – for EFT Issues*

Provider Contact Name*		
Telephone Number*	E-mail Address^	Fax Number

Financial Institution Information*

Financial Institution Name*		
Financial Institution Routing Number*		
Type of Account at Financial Institution*		
<input type="checkbox"/> Checking	<input type="checkbox"/> Savings	<input type="checkbox"/> Lock Box
Provider's Account Number with Financial Institution*		
Account Number Linkage to Provider Identifier* <i>(Must match preference submitted on ERA)</i>		
<input type="checkbox"/> Provider Tax Identification Number (TIN)	<input type="checkbox"/> National Provider Identifier (NPI)	
<small>NOTE: This information is being collected in the event Florida Medicaid changes EFT linkage (which is currently done by Medicaid Provider Identification Number.)</small>		

Submission Information*

Reason for Submission*		
<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Change Enrollment	<input type="checkbox"/> Cancel Enrollment
Include with Enrollment Submission*		
<input type="checkbox"/> Voided Check	<input type="checkbox"/> Bank Letter	
Authorized Signature*		
Printed Name of Person Submitting Enrollment*		
Printed Title of Person Submitting Enrollment*	Submission Date*	

Check here if you have more than one authorized signer. If checked, proceed to page 2.

Florida Medicaid Electronic Funds Transfer (EFT) Authorization Agreement (cont.)

(Submit 2nd page only if needed for additional signatures.)

Authorized Signature*	
Printed Name of Person Submitting Enrollment*	
Printed Title of Person Submitting Enrollment*	Submission Date*

Authorized Signature*	
Printed Name of Person Submitting Enrollment*	
Printed Title of Person Submitting Enrollment*	Submission Date*

Authorized Signature*	
Printed Name of Person Submitting Enrollment*	
Printed Title of Person Submitting Enrollment*	Submission Date*

Instructions for completing the EFT Authorization Agreement

- The authorization form may be accessed via the public web portal (<http://mymedicaid-florida.com>) by selecting Enrollment and then Enrollment Forms. New applicants will be prompted to complete the form online as part of their Medicaid provider application.
- Type or print legibly using blue or black ink if completing the paper authorization.
- Fields marked with an asterisk (*) are required.
- Fields marked with a carat (^) are required if the information is available.
- Each person with signing privileges on the depository account should sign this form. If the account has more than four signers, attach copies of page 2 as needed.
- Attach a voided check or a letter on bank letterhead to certify the routing and account numbers.
- Please allow 3 weeks for processing. If after 3 weeks you do not receive EFT for issued payments, contact the Provider Enrollment Call Center at (800) 289-7799, Option 4 to inquire.