

Medicaid Provider ID: _____
or, Application Tracking Number (ATN) _____



Electronic Funds Transfer Authorization

Provider Name _____

Choose one of the following payment methods:

- If you are an individual or group provider who will receive direct payment from Medicaid, complete **Option 1, Electronic Funds Transfer (EFT)**. NOTE: A letter from the bank on bank letterhead verifying the bank transit / ABA routing number, the account number and account name must be attached to this form. A voided check may be accepted in lieu of the bank letter.
- If you are an individual who will **not** receive direct payment from Medicaid, skip Option 1 and complete **Option 2, Electronic Funds Transfer Exception**, to assign your payment to a group provider. NOTE: If you work for a group **and** will also bill separately for yourself, complete Option 1 entering your individual banking information. *Do not place an employer's information on your individual file.*

Option 1. Electronic Funds Transfer (EFT) Authorization:

Name On Bank Account _____		Bank Account Number _____
Bank Name _____		() Bank Telephone # _____
City _____	Branch _____	State _____
City _____		Zip Code _____
<i>"The undersigned authorize the fiscal agent for the Florida Medicaid Program to make deposits to the checking or savings account at the depository bank indicated."</i>		
Print Name _____	Signature _____	
_____	_____	
_____	_____	
_____	_____	
Note: All individuals authorized to sign on this account must be listed here and must meet Medicaid provider enrollment background screening requirements. Any future changes to this EFT account will require a signature of one of the individuals listed above. If this agreement is for an individual provider number, the individual who owns the number MUST sign here.		

Option 2. Electronic Funds Transfer (EFT) Agreement Exception:

<p>"I work under group provider number _____ and request all disbursements made for services performed by myself be made directly to the group on my behalf. I understand that by requesting this exemption, I will not be able to receive direct disbursements from Medicaid for the services I render, and Medicaid claims filed under my individual provider number will deny."</p>	
Signature of Applicant _____	Title _____
Print Name of Applicant _____	Date _____