Rhode Island Medicaid
Electronic Financial Transaction (EFT)
Authorization Agreement

Electronic Funds Transfer (EFT) is the required payment method to deposit funds for payment. These funds can be credited to either checking or savings accounts, directly into a provider's bank account, provided the bank selected accepts Automated Clearing House (ACH) transactions. EFT also avoids the risks associated with mailing and handling paper checks, ensuring funds are directly deposited into a specific account.

Provided below are instructions for completing the form. When submitting the form, please mail only the completed form, and not the instruction pages.

The EFT Authorization Agreement may be used to **newly enroll** a provider in EFT or **change an existing** EFT.

To complete an EFT Authorization Agreement, you will need the following information:

- National Provider Identifier (NPI) or unique Other Identifier (Medicaid ID) where no NPI is assigned
- Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)
- Provider Taxonomy Code
- Provider Contact Information
- Financial Institution Information

To submit the EFT Authorization Agreement:

- Complete all required fields, verifying information is accurate
- Print the form and obtain written signature of the person authorized to add or change EFT for the provider.
- Include a voided check or letter from the bank for account verification purposes. Deposit slips, handwritten or altered checks are not accepted. Banking information on check must match information on form.
- Mail only the completed form (not instruction pages) to:

Mail: DXC Technology
Attn: Financial Department
PO Box 2010
Warwick, RI 02887

If you have questions regarding the completion of this form, please contact the RI Medicaid Customer Service Help Desk at (401) 784-8100 for local and toll calls, and (800) 964-6211 for in-state toll calls.

Field by Field Instructions

FIELD	DESCRIPTION
Provider Information	
Provider Name	Enter the legal name of the provider to whom payments should be made. This name must be the same as on the bank account, the provider file, and the supporting documentation.
Provider Identifiers Information	
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	Enter the Tax ID of the provider for which the EFT Authorization Agreement applies.
National Provider Identifier (NPI)	Enter the NPI of the provider for which the EFT Authorization Agreement applies. If the provider does not have an NPI, go to the Other Identifier field.
Other Identifier(s)	If provider does not have an NPI, enter the unique Medicaid ID number.
Assigning Authority	If other than NPI is used, check Medicaid.
Provider Taxonomy Code	Enter the taxonomy code associated to the NPI for this provider. If the provider has multiple, enter one of the taxonomy codes. If provider does not have an NPI, this field will be blank.
Provider Contact Name	Enter the name of the person who should be contacted with questions on the EFT form.
Title	Enter the title of the contact person.
Telephone Number	Enter the telephone number including extension for the contact person.
Email Address	Enter the email address for the contact person.
Fax Number	Enter the fax number for the contact person.
Financial Institution Name	Enter the name of the financial institution where the bank account is held.
Financial Institution Address	Enter the Street, City, State and Zip Code for the bank where the account is held.
Financial Institution Telephone Number	Enter the bank phone number including extension if applicable.
Financial Institution Routing Number	Enter the routing number for the bank account.
Type of Account at Financial Institution	Check the type of bank account (Checking / Savings)
Provider's Account Number with Financial Institution	Enter the account number of the bank account. Enter only numeric values; no hyphens, spaces or other special characters.
Account Number Linkage to Provider Identifier	Select Provider Tax Identification Number (TIN) (if identifier other than NPI is used), or select NPI.
Reason for Submission	Select the appropriate reason for completing this form.
Include with Enrollment Submission	Check appropriate box, voided check or bank letter. One item MUST be checked and included.
Written Signature Person Submitting the Enrollment	Original signature of authorized person.
Printed Name of Person Submitting the Enrollment	Print name of authorized person.
Printed Title of Person Submitting the Enrollment	Enter title of the authorized person.
Submission Date	Enter the date in MM/DD/CCYY format for the date of submission.

Rhode Island Medicaid
Electronic Financial Transaction (EFT)
Authorization Agreement

Provider Information		
Provider Name:		
Provider Identifiers Information		
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):		National Provider Identifier (NPI):
Other Identifier(s):		Assigning Authority: ☐ Medicaid
Provider Taxonomy Code:		
Provider Contact Information		
Provider Contact Name:		Title:
Telephone Number:	Ext.	Email Address:
Fax Number:		
Financial Institution Information		
Financial Institution Name:		Financial Institution Address:
Financial Institution Telephone Number:	Ext.	Financial Institution Routing Number:
Type of Account at Financial Institution: ☐ Checking ☐ Savings		Provider's Account Number with Financial Institution:
Account Number Linkage to Provider Identifier: ☐ Provider Tax Identification Number (TIN) *(if identifier other than NPI is used)* ☐ National Provider Identifier (NPI)		
Submission Information		
Reason for Submission: ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment		
Include with Enrollment Submission: ☐ Voided Check ☐ Bank Letter		

I agree to keep, and disclose upon request to authorized agencies, records which disclose fully the extent of payments claimed from the services rendered to recipients of the Medicaid Program. I accept as payment in full the amount paid by the Medicaid Program for claims submitted with the exception of authorized cost sharing by recipients. I understand payment of this claim 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. This is to certify that the information submitted to obtain this payment is true, accurate and complete.

I authorize the electronic transfer of Rhode Island Medicaid payments made to the above provider NPI.
I understand that I am responsible for the validity of the above information.

_____ _____

Written Signature of Person Submitting Enrollment **Printed Name of Person Submitting Enrollment**

_____ _____

Printed Title of Person Submitting Enrollment **Submission Date**