

<b>Electronic Funds Transfer (EFT)</b>
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**RHODE ISLAND MEDICAID PROGRAM  
AUTHORIZATION FOR DIRECT DEPOSIT**

Effective May, 2009, all providers enrolled with Rhode Island Medicaid are required to have Electronic Funds Transfer to receive payment.

Complete the section below and attach a copy of a voided check for a checking account, or a letter from the bank or financial institution for a savings account. The transaction routing number can be obtained from your bank.

PROVIDER NAME	PROVIDER NPI and TAXONOMY *
	NPI :
	Taxonomy :

*\* Please note : This EFT request will apply to all Medicaid ID's associated with this NPI/Taxonomy combination.*

BANK NAME	TRANSACTION ROUTING NUMBER
BANK ADDRESS	ACCOUNT NUMBER
BANK PHONE NUMBER	
	CHECKING _____ SAVINGS _____

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.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Contact Phone Number

\*\*\*\*\*Hewlett Packard Enterprise USE ONLY\*\*\*\*\*

<b>DATE PROCESSED</b>	<b>INITIALS</b>
<b>DATE VERIFIED</b>	<b>INITIALS</b>