New Hampshire Title XIX Medicaid Program

ELECTRONIC FUNDS TRANSFER (EFT) ENROLLMENT APPLICATION

Providers who receive payment of claims via Electronic Funds Transfer from the NH Department of Health and Human Services' (The Department) Title XIX Program must agree to the following terms and conditions:

1. **Legal Compliance**. Provider shall abide by all Federal and State laws governing the NH Title XIX Program.
2. **EFT Information**. Provider will complete EFT information on this form and submit a bank letter or voided check from the account to which funds will be transferred.
3. **Non-provider Payee**. Designation of a payee other than the Provider shall not relieve the Provider of any liability for acceptance of medical assistance payments under the NH Title XIX Program. Provider acknowledges and agrees that Payee is not an individual or organization, such as a collection agency or service bureau, that advances money based on future NH Title XIX payments (accounts receivable) due to Provider after agreeing to sell, transfer, or assign such rights to payment to the individual or organization for an added fee or a percentage of the accounts receivable. Any payments to the Payee shall be based solely upon the delivery by the provider of appropriate medical assistance under the NH Title XIX Program, and shall not include any cost of processing or be based on the percentage of amounts paid or upon collection of the payments.
4. **Acceptance of Funds**. Provider agrees that evidence of credit to the proper account by Payee's bank pursuant to an EFT is sufficient to show acceptance of medical assistance payments under the NH Title XIX Program. Provider certifies by such acceptance that Provider presented the claims for the services shown on the Remittance Advice issued by the Department, and that the services were rendered by or under the supervision of Provider. Provider understands that payment will be from Federal and State funds, and that any falsification or concealment of a material fact may be prosecuted under Federal and State laws.
5. **Notice of Changes**. Provider will notify the Department in writing at least ten (10) days in advance of any changes in Payee, Payee's name or address, or bank account name or number (supported by a bank letter or voided check on the new account).
6. **Alternate Payment Methods**. For good cause (including but not limited to recovering overpayments from subsequent requests for claims payments), the Department may substitute payment by check for EFT until the cause requiring the substitution has been satisfied as determined by the Department. Payment by check will be made to the billing address for payments on record with the Department.
7. **Incorporated Document**. This EFT Agreement is incorporated into the NH Title XIX Provider Participation Agreement and shall not modify or eliminate any provision of the NH Title XIX Provider Participation Agreement (including applicable policies and procedures manuals of the Department), except as specifically provided herein.
8. **Expiration or Termination of EFT**. Violation of these terms may cause termination of EFT and/or the NH Title XIX Provider Participation Agreement by the Department. Expiration or termination of the NH Title XIX Provider Participation Agreement for any reason will terminate EFT automatically. The Department will give written notice of termination to the Provider.
9. **CCD+ Format.** Provider will contact its financial institution/bank to arrange for the delivery of the information from the CCD+ EFT that is necessary for successful re-association of the EFT payment with the ERA remittance advice. The information that the bank must return is as follows:

CORE-required Minimum CCD+ Re-association Data Elements		Corresponding v5010 X12 835 Data Elements	
CCD+ Record #	**Field #**	**Field Name**	**Data Element Segment Position, Number & Name**
5	9	Effective Entry Date	BPR16-373 Date (EFT Effective Date)
6	6	Amount	BPR02-782 Monetary Amount (Total Actual Provider Payment Amount)
7	3	Payment Related Information	TRN Re-association Trace Number Segment

TRN segment consists of Check or EFT trace number/Payer Identifier/optional supplemental code. These pieces of information will match what is received in the ERA (835) transaction for easy re-association.
Providers must contact their financial institution to arrange for the delivery of the minimum required fields for re-association. The banks will not automatically supply this detail and it is required that the provider work out how this information will be obtained (email, e-statement, electronically, etc.).

10. **Late/Missing EFT.** In case of a late or missing EFT, the Provider will contact the Provider Relations call center at 866-291-1674. Late or missing is defined as a maximum elapsed time of four (4) business days following the receipt of ERA.
11. **Change/Cancel Enrollment.** If any changes are required to EFT enrollment information, the Provider will contact the Provider Relations call center at 866-291-1674.
12. **TIN/FEIN.** Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) field in the EFT section is equivalent to Social Security Number (SSN) for Individual Providers and Federal Employer Identification # (FEIN) for Group Providers.

1. Provider Information:

*Provider Name

Doing Business As Name (DBA)

Provider Address:

*Street

*City

*State/Province

*Zip Code/Postal Code

2. Provider Identifier Information:

*Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)

National Provider Identifier (NPI)

Provider License Number

License Issuer

Provider Type

Provider Taxonomy Code

3. Provider Contact Information:

*Provider Contact Name

Title

*Telephone Number

Telephone Number Extension

Email Address

Fax Number

4. Financial Institution Information:

Financial Institution Name

*Street

*City

*State/Province

*Zip Code/Postal Code

*Financial Institution Telephone Number

*Financial Institution Routing Number

*Type of Account at Financial Institution

☐ Checking ☐ Saving ☐ Other

*Provider Account Number with Financial Institution

*Account Number Linkage to Provider Identifier

☒ Provider Tax Identification Number (TIN)

5. Submission Information:

Reason for Submission

☒ New Enrollment

Authorized Signature

Written Signature of Person Submitting Enrollment