Medi-Cal Rx Electronic Funds Transfer (EFT) Authorization Agreement Form

Instructions: Carefully read and complete the EFT authorization form. By submitting this form, the provider is authorizing Medi-Cal Rx to electronically post or cancel posting of payments into their designated bank account. This authorization remains in effect until Medi-Cal Rx receives written notification from the provider of its termination, or until Medi-Cal Rx or appointing authority deems it necessary to terminate the agreement.

Providers can either submit this form or use the Medi-Cal Rx Web Portal (at https://medi-calrx.dhcs.ca.gov/provider) to provide new or modified EFT account information or to cancel EFT enrollment. A provider must be a registered Medi-Cal Rx Web Portal user to update their EFT information online. Once registered, log in and select **Finance Portal** from the left-hand menu to access the banking information page.

For providers opting to use this form, print and mail the form as per the instructions in the *Form Submission* section. Explanations regarding form fields are located below the form in the *Explanation of EFT Authorization Agreement Form* section. Incomplete forms will not be processed and will be returned to the provider.

*** Indicates Required Field**

* PART 1 – Reason for Submission

- ◯ **New Enrollment:** Select this option if you are establishing EFT payments from Medi-Cal Rx. Allow a minimum of 45 days for EFT to begin. Attach with this application an original preprinted voided check (for checking accounts) or an original letter from the bank on the bank's letterhead (for savings accounts) verifying the account to which you want payments deposited. The Provider Name, Routing Number, and Account Number on either of these documents must match what is entered on this application. The bank letter must be signed and dated by a bank representative using blue ink.
- ◯ **Change Enrollment:** Select this option if you are changing your financial institution, account number, type of account, etc., for Medi-Cal Rx payments. Do not close your old account until this change takes place. Allow a minimum of 45 days for the EFT change to become effective. Attach with this application an original preprinted voided check (for checking accounts) or an original letter from the bank on the bank's letterhead (for savings accounts) verifying the account to which you want payments deposited. The Provider Name, Routing Number, and Account Number on either of these documents must match what is entered on this application. The bank letter must be signed and dated by a bank representative using blue ink.
- ◯ **Cancel Enrollment:** Select this option if you want to cancel EFT payments from Medi-Cal Rx. Include your NPI and pharmacy information with this application. Allow a minimum of 45 days for cancellation to take effect. A provider whose EFT is cancelled must reapply and submit a new EFT authorization form for reinstatement.

PART 2 – Provider Information	
*Provider Name:	
*Street:	
*City:	
*State:	*ZIP Code:
*Telephone Number:	Telephone Extension:
Email Address:	

PART 3 – Provider Identifiers
This form accommodates up to three pharmacies to be included in this EFT agreement. If you list multiple provider identifiers on this form, all of the providers *must* be associated with this same ownership. To include more than three pharmacies in the EFT or to register an entire chain by NCPDP Chain Code, update EFT information online using the Medi-Cal Rx Web Portal link listed above.
Provider 1
*Federal Tax ID # (TIN) / Employer ID # (EIN) or Social Security # (SSN):
*National Provider Identifier (NPI):
*Owner # *(see Explanation of Form Fields below)*:
Provider 2
*Federal Tax ID # (TIN) / Employer ID # (EIN) or Social Security # (SSN):
*National Provider Identifier (NPI):
*Owner # *(see Explanation of Form Fields below)*:

Provider 3
*Federal Tax ID # (TIN) / Employer ID # (EIN) or Social Security # (SSN):
*National Provider Identifier (NPI):
*Owner # *(see Explanation of Form Fields below)*:

PART 4 – Provider Contact Information *(Point of Contact for EFT)*
*Contact Name:
*Telephone Number:
Telephone Extension:
*Email Address:
Fax Number:

PART 5 – Financial Institution Information	
*Financial Institution Name:	
*Street:	
*City:	
*State:	*ZIP Code:
*Type of Account *(Checking or Savings)*:	
*Financial Institution Routing Number:	
*Provider's Account Number:	

Privacy Statement (Civil Code Section 1798 et seq.): The information requested on this form is required by the Department of Health Care Services for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your request being delayed or not processed.

* PART 6 – Provider Certification

By signing this form, I am certifying that I have legal authority to make these changes. I understand that by signing this form, payments issued 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.

Original Signature Required; Use Blue Ink

Signature of Authorized Person Submitting Form:

_____

Date: _____

Print Name: _____ **Title:** _____

Unofficial unless stamped by Notary Public:

Notarized By: _____

On _____ **(Date)**

Notary Public Number: _____

OFFICE USE ONLY Date Received: _____ Date Completed: _____

Completed by Name: _____

Form Submission

Verify that all information is correct, complete, and that the form is signed using blue ink and notarized.

Print and mail this form to the address below. For assistance in completing the form or to check the status of your form, contact Medi-Cal Rx Customer Service at the phone number below.

Medi-Cal Rx Customer Service Center
ATTN: Financial Inquiries
P.O. Box 610
Rancho Cordova, CA 95741-0610
Phone: 1-800-977-2273 (Select Option 2 for Pharmacy, enter your NPI, and then select Option 2 for Checkwrite)

Explanation of EFT Authorization Agreement Form

The supplied Provider Information and Provider Identifiers on this form must match the current information on file with the DHCS Provider Enrollment Division (PED). If it does not match, the application will not be approved. If information on file with PED is out of date, update the information through the Provider Application and Validation for Enrollment (PAVE) Portal found at https://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx prior to submitting this form.

Explanation of Form Fields

Provider Information

Provider Name: Complete legal name of institution, corporate entity, practice, or individual provider.

Address fields: Provider's pay-to address (number, street name, city, state, and ZIP Code).

Telephone Number: Telephone number associated with the provider, with no dashes or spaces (e.g., 8888888888).

Telephone Extension: Provider's telephone extension, if applicable.

Email Address: Electronic mail address at which Medi-Cal Rx staff may contact the provider.

Provider Identifiers

Federal Tax ID # (TIN) / Employer ID # (EIN) or Social Security # (SSN): A Federal TIN, also known as an EIN, is used to identify a business entity. This must match the TIN/EIN that is on file with Medi-Cal. Include an SSN if the provider does not have a TIN/EIN.

National Provider Identifier (NPI): A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA.

The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

Owner #: Enter the owner number associated with the provider. The owner number can be found on the provider's Medi-Cal Rx Remittance Advice Detail or by calling Medi-Cal Rx at 1-800-977-2273 (select Option 2 for Pharmacy, enter your NPI, and then select Option 2 for Checkwrite). Note: If the owner number is updated by PED, the provider must submit a new EFT Authorization Agreement.

Provider Contact Information *(Point of Contact for EFT)*

Contact Name: Name of a contact in the provider office for handling EFT information.

Telephone Number: Telephone number associated with the contact person, with no dashes or spaces (e.g., 8888888888).

Telephone Extension: Contact person's telephone extension, if applicable.

Email Address: Electronic mail address at which Medi-Cal Rx staff may reach the contact person.

Fax Number: Number at which the provider can be sent facsimiles, with no dashes or spaces (e.g., 8888888888).

Financial Institution Information

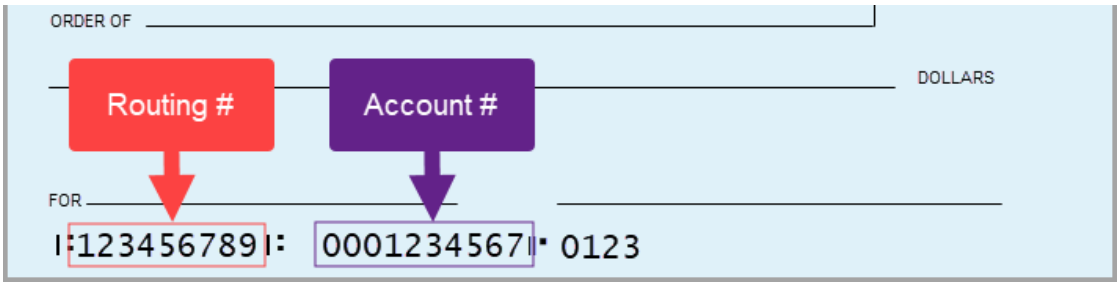
Financial Institution Name: Official name of the provider's financial institution.

Address fields: Address (number, street name, city, state, and ZIP Code) associated with the receiving depository financial institution.

Type of Account: The type of account the provider will use to receive EFT payments (e.g., Checking or Savings).

Financial Institution Routing Number: A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited, including any leading zeros (see image below). Do *not* include any dashes or spaces.

Provider's Account Number: Provider's account number at the financial institution to which EFT payments are to be deposited, including any leading zeros (see image below). Do *not* include any dashes or spaces.



Provider Certification

Signature of Authorized Person Submitting Form: The signature of an individual authorized by the provider or its agent to initiate, modify, or terminate an EFT enrollment. By signing the form, this person certifies that they have legal authority to make these changes. An original signature is required and must be in blue ink.

Date: The date on which the EFT enrollment form is signed.

Print Name: Print the name of the person signing the form.

Title: Print the title of the person signing the form.

Notarized By: Print the name of the Notary Public.

On (Date): The date the form was notarized.

Notary Public Number: The Notary Public's number.

Unofficial unless stamped by Notary Public: The Notary Public applies their stamp in this box.