| Addendum/Maintenance Form

IHCP Provider Electronic Funds Transfer Addendum/Maintenance Form

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Electronic Funds Transfer Overview

The Indiana Health Coverage Programs (IHCP) will establish a direct deposit account with your financial institution for claims payment. After you have established electronic funds transfer (EFT), the IHCP will electronically transfer payments into the account you specify on this form. Please read the instructions on this form carefully and ensure that the appropriate signature and attachment are included.

All claims successfully processed by Wednesday at 4:30 p.m. will appear on the weekly Remittance Advice, which is available on Monday of the following week. EFT payments occur each Wednesday.

It takes approximately 18 days for the bank to process and completely establish your EFT account. If you bill claims before your EFT activation, paper checks are mailed to the *Pay To* address documented on Schedule A of the IHCP Provider Packet. When your EFT account becomes active, direct deposits begin. Thank you for considering EFT as a payment option.

HPE Provider Enrollment Unit
P.O. Box 7263
Indianapolis, IN 46207-7263

Electronic Funds Transfer Form Instructions	
Provider Name	Enter the legal name of institution, corporate entity, practice, or individual provider.
Street	Enter the street address of the provider's home office.
City	Enter the city associated with provider's home office address.
State/Province	Enter the two-character state code associated with the provider's home office address.
ZIP Code/Postal Code	Enter the U.S. postal-zone code (ZIP + 4) associated with the provider home office.
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	Enter the federal Tax Identification Number (TIN), also known as the Employer Identification Number (EIN), used to identify the business entity.
National Provider Identifier (NPI)	The NPI is a unique identification number for registered healthcare providers; enter the provider's NPI.
Assigning Authority	Enter the provider's Legacy Provider Identifier (LPI) in Field 8a and Service Location Code in Field 8b.
Provider Contact Name	Enter the name of a contact in the provider's office who handles EFT issues.
Telephone Number	Enter the telephone number associated with the EFT contact person.
Email Address	Enter the electronic mail address associated with the EFT contact person.
Does account belong to a provider agent (billing agency)?	**Select "Yes" if the EFT for the provider named on this document will be sent to an account belonging to a billing agency and not to the account of the provider.** Select "No" if the EFT for the provider named on this document will be sent to an account belonging to the provider.
Provider Agent Name	Enter the name of provider's authorized provider or billing agent.
Street	Enter the street address for the provider's billing agent.
City	Enter the city associated with the street address for the provider's billing agent.
State/Province	Enter the two-character code for the state associated with the provider's billing agent.
ZIP Code/Postal Code	Enter the U.S. postal-zone code (ZIP + 4) associated with the provider's billing agent.
Provider Agent Contact Name	Enter the name of a contact in the provider's billing agent office who handles EFT issues.
Title	Enter the title of the contact in the provider's billing agent office.
Telephone Number	Enter the telephone number associated with the contact in the provider's billing agent office.
Email Address	Enter the electronic mail address associated with the contact in the provider's billing agent office.
Financial Institution Name	Enter the official name of the financial institution where the provider maintains an account where payments are to be deposited.
Financial Institution Telephone Number	Enter a contact telephone number at the financial institution where the provider maintains an account where payments are to be deposited.
Financial Institution Routing Number	Enter the nine-digit identifier of the financial institution where the provider maintains an account where payments are to be deposited.
Type of Account at Financial Institution	Enter the type of account the provider will use to receive EFT payments; for example, checking or savings.
Provider's Account Number with Financial Institution	Enter the account number at the financial institution where EFT payments are to be deposited.
Account Number Linkage to Provider Identifier-Provider Tax Identification Number (TIN)	Enter the nine-digit tax identification number that ties the provider to his or her EFT account where payments are to be deposited.
Reason for Submission	Select "New Enrollment," "Change Enrollment," or "Cancel Enrollment" to indicate the reason or type of EFT transaction being submitted.
Authorized Signature	Written Signature of Person Submitting Enrollment: This signature must be an authorized official or owner of the provider, per the instructions outlined in the *Authorized Signature Section* of the form.
Authorized Signature	Printed Name of Person Submitting Enrollment: Enter the printed name of the person signing the form.
Authorized Signature	Printed Title of Person Submitting Enrollment: Enter the title of the person signing the form.
Submission Date	Enter the date on which the enrollment is submitted.

General Information

Complete all fields on form, and follow attachment instructions below. Confirm financial institution routing number.

1. Provider Name		2. Street Address	3. City
4. State/Province	5. Zip Code/Postal Code	6. Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	7. National Provider Identifier (NPI)
8. Assigning Authority 8a: 8b:	9. Provider Contact Name	10. Telephone Number	11. Email Address

Provider Agent Information

12. Does account belong to a provider agent (billing agent)? If yes, please complete this section. If no, this section is not required:

☐ Yes ☐ No

The following section must be completed if the EFT for the provider named on this document will be sent to an account belonging to a provider billing agent and not an account of the provider.

The exception for a provider billing agent is limited to agents who furnish statements and receive payments in the name of the provider, and the service provided by the agent is: (1) related to the cost of processing the bill; (2) not related to a percentage or other basis to the amount billed or collected; and (3) not dependent on the collection of payment. Further, a payment for a provider may not be made to or through an individual or organization (collection agency or service bureau), or by power of attorney thereof, that advances money for accounts receivable a provider has assigned, sold, or transferred to the individual or organization for a fee or deduction of accounts receivable.

13. Provider Agent Name		14. Street	15. City
16. State/Province	17. Zip Code/Postal Code	18. Provider Agent Contact Name	19. Title
20. Telephone Number	21. Email Address		

Financial Institution Information

22. Financial Institution Name	23. Financial Institution Telephone Number	24. Financial Institution Routing Number	25. Type of Account at Financial Institution ◯ Checking ◯ Savings
26. Account Number with Financial Institution		27. Account Number Linkage to Provider Identifier Provider Tax Identification Number (TIN)	28. Reason for Submission ◯ New Enrollment ◯ Change Enrollment ◯ Cancel Enrollment

Attachment (Required)

Attach one of the following documents to this form for verification of account owner and account number:
(1) voided check or (2) a signed letter from your financial institution that lists the account holder's name, taxpayer identification number (TIN), and the appropriate account and routing numbers.

Authorized Signature Section

On behalf of the provider entity named above, I agree to keep, and disclose upon request to authorized agencies, records that fully disclose the extent of claim payments received from and services rendered to members of the Indiana Health Coverage Programs (IHCP). I accept, as payment in full, the amount paid by the IHCP for claims submitted with the exception of authorized cost sharing by members. I understand payment of IHCP claims 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. I ensure that this EFT request complies with the regulation set forth in *42 CFR 447.10*, which prohibits State payments for any IHCP service to be made to anyone other than an enrolled provider, a noncash member, or to one of the listed exceptions. I understand that an IHCP payment may be sent via EFT to an account held by the following only: (1) an enrolled provider; (2) a noncash member; (3) a government agency on reassignment by an enrolled provider (IRS); (4) a third party by court order on reassignment by an enrolled provider (child support); (5) a business agent (billing service, account firm) if three specific criteria are met (see Provider Agent Information section); (6) the employer of a practitioner (if a contract so requires); or (7) a healthcare facility, or a healthcare delivery system (if a contract so requires), if the organization itself submits the claim directly to the IHCP.

I authorize the electronic transfer of IHCP payments (including 590, Medicaid, and Package C) be made to the above provider number. I understand that I am responsible for the validity of the above information. I agree to notify IHCP within ten days of any change in any of the information included on this form.

This section must be completed by an authorized official or owner of the billing provider. A delegated administrator may sign this form. The *IHCP Delegated Administrator Addendum/Maintenance Form* must be completed before a delegated administrator can sign forms. The delegated administrator can sign only for items expressly delegated. The IHCP can process requests only when the appropriate signature is present.

Authorized Signature: _____ Written Signature of Person Submitting Enrollment	_____ Printed Title of Person Submitting Enrollment
_____ Printed Name of Person Submitting Enrollment	Submission Date: _____