



Electronic Funds Transfer Overview

The Indiana Health Coverage Programs (IHCP) will establish a direct deposit account with your bank 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 Friday 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 prior to 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.



General Information			
Complete all fields on form, and follow attachment instructions below. Confirm bank's ABA transit routing number.			
1. Provider Legal Name:		2. Legacy Provider Identifier (LPI):	3. Service Location (alpha suffix):
4. Provider Taxpayer Identification Number (TIN):	5. National Provider Identifier:	6. Taxonomy	7. Provider Location ZIP + 4:
8. Name on Bank Account:		9. Bank Name:	10. TIN of Account Holder:
11. ABA Transit Routing Number:		12. Bank Account Number:	
13. Bank Address:			
14. Bank City:		15. Bank State:	16. Bank ZIP + 4:
17. Bank Telephone Number:		18. Type of Account Savings Checking	
19. Type of Authorization: Start Cancel Change		20. Transaction request is due to Change of Ownership Yes No	
Contact Information			
The contact name and email relate to the person who can answer questions about the information provided in this packet.			
21. Contact Name:		22. Telephone:	
23. Contact Email Address:			

Authorized Signature Section

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

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 non-cash 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) to an enrolled provider; (2) a non-cash 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 Billing Agent Information); (6) the employer of a practitioner (if a contract so requires); or (7) a health care facility, or a health care 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.

24 Authorized Official's Name (please print):	25. Title:
26. Authorized Official's Signature:	27. Date:

Billing Agent Information

28. Does account belong to billing agency? 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 a bank account belonging to a billing agent and not the bank account of the provider.

The exception for a business 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 upon 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.

29. Billing Agent Name:	30. Telephone Number:	31. Billing Agent's TIN:
32. Billing Agent Address:		
33. Billing Agent City:	34. Billing Agent State:	35. Billing Agent ZIP + 4:
36. Authorized Billing Agent Contact Name:	37. Title:	
38. Authorized Billing Agent Signature:	39. Date:	