VERMONT HEALTH ACCESS
AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER

➔Attach a copy of a voided check

PROVIDER NAME	PROVIDER NUMBER

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 and services rendered to recipients of Medicaid. I accept as payment in full the amount paid by Medicaid 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 Vermont Medicaid payments made to the above provider number. I understand that I am responsible for the validity of the above information.

NOTE: **This EFT will not take effect until we are able to TEST with the bank to verify the accuracy of the information provided. A MOCK DEPOSIT WILL BE EXECUTED ONLY IF YOU BILL US. After 2 successful $0 deposits, we will start depositing money into the new bank account above**.

PRINT NAME OF PERSON SIGNING_____

_____ _____ _____
Signature Date Phone #

As of January 1, 1997, it is mandatory for all providers to receive Vermont Medicaid payments via Electronic Funds Transfer (EFT).

********** HP USE ONLY **********

EFT STATUS	DATE SUBMITTED	DATE VERIFIED	TEST DATES

This form can be faxed, attn: Enrollment, at 802-878-3440 or mailed to:
HP Enterprise Services
PO Box 888
Williston, VT 05495