LOUISIANA DEPARTMENT OF HEALTH

gainwell

Louisiana Medicaid Program

Louisiana Medicaid Direct Deposit (EFT) Authorization Agreement For Entity/Business Providers

(Enrollment packet is subject to change without notice)

Revised 10/2020

LOUISIANA DEPARTMENT OF HEALTH (LDH)
LOUISIANA MEDICAID DIRECT DEPOSIT ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

GENERAL INFORMATION

Instructions for Completion:

- Only an authorized representative may sign this form. This authorized representative must be someone designated to enter into a legal and binding contract with Louisiana Medicaid. This person must be someone currently listed on the Disclosure of Ownership as either an owner or managing employee. Any other signature will be grounds for rejecting this form.

- Original signatures only; no stamps or copied signatures will be accepted. (Blue ink preferred – not black ink).

- The provider name on this form must match the provider name associated with the Louisiana Medicaid number, the NPI, or both.

- If the entity/business is doing group billing, then an EFT form is required for the group only, and not the individual providers.

- Call Gainwell Provider Enrollment at (225) 216-6370 if you have questions regarding the completion of this form or the status of your request.

Late or Missing EFT Payments:

- Once you are enrolled for EFT and your electronic payments are missing or late, first contact the Automated Clearinghouse (ACH) representative at your bank, not a bank teller.

- If the bank is unable to locate the deposit, check to ensure that the account has not been closed or changed.

- If still unable to locate a deposit, call Gainwell Provider Enrollment and report the late and/or missing EFT transaction.

Remittance Advice Data

- If you sign up for EFT and also receive your remittance advice data in the v501x12 835 transaction (ERA), you must contact your financial institution if you wish to arrange for delivery of the CORE-required Minimum CCD+ data elements needed for re-association of the payment and the ERA.

Send your completed EFT Form to:

Gainwell Provider Enrollment Unit
P.O. Box 80159
Baton Rouge, LA 70898-0159

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INSTRUCTIONS

Field	Instruction
1. Provider Name	Complete legal name of institution, corporate entity, practice or individual provider.
2. Doing Business As (DBA) Name	The name by which the provider is conducting business.
3. Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	A Federal Tax Identification Number (TIN), also known as an Employer Identification Number (EIN), used to identify a business entity (9 digits).
4. National Provider Identifier (NPI)	A Health Insurance Portability and Accountability Act (HIPAA) identification number 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.
5. Louisiana Medicaid Provider Number (7 digits)	The provider's 7-digit Louisiana Medicaid identification number.
6. Provider Contact Name	Name of a contact in the provider office for handling EFT issues.
7. Provider Contact Telephone Number	The telephone number associated with the Provider Contact Name.
8. Provider Contact Email Address	An electronic mail address at which the health plan might contact the provider.
9. Financial Institution Name	The official name of the provider's financial institution.
10. 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.
11. Type of Account at Financial Institution	The type of account the provider will use to receive EFT payments, e.g., Checking, Saving (check the appropriate box).
12. Provider Account Number with Financial Institution	Provider's account number at the financial institution to which EFT payments are to be deposited (up to 10 digits).
13. Is the bank account you specified located in the United States?	Check yes or no. If no, please provide the country of location of the account.
14. Account Number Linkage to Provider Identifier	Check one: Provider Tax Identification Number (TIN), or National Provider Identifier (NPI).
15. Reason for Submitting this form	Indicate the reason for submission of the form: New Enrollment, Change of Ownership (CHOW), Re-validation of Existing Enrollment, Re-enrollment or Other.

NOTE: If a change of ownership (CHOW) occurs, an entire enrollment packet is required and direct deposit information cannot be changed for the current provider account.

Field	Instruction
16. Voided Check	Attach a voided check for verification of financial institution account and routing number. **Deposit slips are not accepted.**
17. Signature of Authorized Representative	Signature of authorized representative in blue ink.
18. Printed Name of Authorized Representative	The printed name of the authorized representative.
19. Printed Title of Authorized Representative	The printed title of the authorized representative.
20. Date of Signature	The date the form is completed. Format: MMDDYY

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1. Provider Name ______________________________
2. Doing Business As (DBA) Name ______________________________
3. Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) (9 digits) ☐☐☐☐☐☐☐☐☐
4. National Provider Identifier (NPI) (10 digits) ☐☐☐☐☐☐☐☐☐☐
5. Louisiana Medicaid Provider Number (7 digits) ☐☐☐☐☐☐☐
6. Provider Contact Name ______________________________
7. Provider Contact Telephone Number ______________________________
8. Provider Contact Email Address ______________________________
9. Financial Institution Name ______________________________
10. Financial Institution Routing Number (9 digits) ☐☐☐☐☐☐☐☐☐
11. Type of Account at Financial Institution (check one) ☐ CHECKING ☐ SAVINGS
12. Provider Account Number with Financial Institution ☐☐☐☐☐☐☐☐☐☐
13. Is the bank account you specified located in the United States? ☐ Yes ☐ No
    If no, identify the country of location: ______________________________
14. Account Number Linkage to Provider Identifier (check one) ☐ Provider Tax Identification Number (TIN) ☐ National Provider Identifier (NPI)
15. Reason for Submitting this form ☐ New Enrollment ☐ CHOW ☐ Re-validation of Existing Enrollment
    Re-enrollment ☐ Other ______________________________
16. Attach a voided check with this document for verification of financial institution account and routing number. **Deposit slips are not accepted.**

- The provider understands that payment and satisfaction of this claim will be from Federal and State Funds and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal and State laws.
- **The provider understands that LDH may revoke this authorization at any time.**
- The provider hereby authorizes the Louisiana Department of Health to present credit entries into the account and depository named above. These credits will pertain **only to direct deposit transfer payments** that the payee receives from Medicaid.
- The provider certifies that if a Board of Directors' approval is necessary to enter into this agreement, that approval has been obtained and the signature below has been authorized by the stated Board of Directors to enter into this agreement.
- The provider agrees to notify the Provider Enrollment Unit if changing financial institutions or accounts and understands that the maintenance of account information on the Louisiana Medicaid files is the provider's responsibility. Failure to notify the Provider Enrollment Unit may result in Medicaid payments being electronically transmitted to incorrect accounts. The provider understands that such changes may not be accommodated if less than a 15 business day notice is given.
- Only an authorized representative may sign this form. This authorized representative must be someone designated to enter into a legal and binding contract with Louisiana Medicaid on behalf of the provider.

______________________________ ______________________________
17. Signature of Authorized Representative — 18. Print Name of Authorized Representative

______________________________ ______________________________
19. Print Title of Authorized Representative — 20. Date of Signature