



AUTHORIZATION AGREEMENT FOR STATE MEDICAID PAYMENTS

- To **APPLY** for EFT, to **CHANGE** bank information on existing EFT or to **DELETE** participation in EFT, select the type of transaction, then TYPE or PRINT the information requested in **Sections 1 and 2 below**.
- Sign, date and return this form, along with a **COPY OF A VOIDED CHECK** (in case of a savings account, a letter from your bank stating your account and routing number) to: OFFICE OF BUDGET & MANAGEMENT
PAYMENT ISSUANCE
30 EAST BROAD STREET, 34TH FLOOR
COLUMBUS, OHIO 43215 – 3457
- You may FAX **CHANGES AND DELETES ONLY** TO: (614) 728-8750, OTHERWISE WE MUST RECEIVE THE ORIGINAL AGREEMENT.
- It is the **Provider's responsibility** to keep the Ohio Department of Job and Family Services informed of any **NAME** and/or **ADDRESS** changes. Call Provider Enrollment at (800) 686-1516 for information to change a name or address.

SECTION 1

Type of Transaction: _____ ADD (new applicant) _____ CHANGE bank information _____ DELETE (stop EFT)																					
Provider Name (as listed on W-9) _____	(Area Code) Telephone Number _____																				
Provider Mailing Address _____	City _____ State _____ Zip Code _____																				
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Federal Tax ID Number or Social Security Number	ODJFS Medicaid Provider Number																				

- Select Type of Transaction. If you are DELETING your EFT DO NOT FILL OUT SECTION 2.
- Enter the provider's name, address and phone # according to the records maintained by the Ohio Department of Job and Family Services.
- Enter the Federal Tax ID Number (either Employer's Identification Number or Social Security Number).
- Enter the Provider Number LINKED TO THIS FEDERAL TAX ID as assigned by the Department of Job and Family Services.

****THE PROVIDER NAME, TAX IDENTIFICATION NUMBER AND PROVIDER NUMBER MUST MATCH THE W-9 ON FILE WITH MEDICAID. MAKE SURE YOUR TAX ID MATCHES THE PROVIDER NUMBER ON FILE WITH MEDICAID OR YOUR FORM WILL BE RETURNED. IF IN DOUBT, VERIFY THIS WITH PROVIDER ENROLLMENT BEFORE SUBMITTING THIS FORM (800) 686-1516.**

SECTION 2

Financial Institution Name _____	Contact Person _____	(____) _____ Area Code and Phone No.															
Financial Institution Mailing Address _____	City _____	State _____ Zip Code _____															
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Provider's Account Number at Financial Institution																	

- Enter the name, address and phone # of the financial institution in which deposits are to be made.
 - Enter the nine digit transit routing/ABA number encoded at the bottom of your check.
 - Enter the account number to which EFT transactions are to be accredited.
 - Check mark the type of account. Only two types of accounts are available.
- If you are unsure about any of your banking information, please contact your financial institution about ACH transfers.
- Whereby authorize the State Accounting's Office to initiate credit entries to our account in the financial institution identified above and also debit entries, if necessary, for any credit entries that are determined to be in error. We additionally authorize the financial institution to credit or debit the same to our account.
 - This authority is to remain in effect until revoked by us in writing to the State Accounting's Office.

Signature of Provider or Designee

Title of Signer

Provider Name Typed or Printed

Date

Do Not Write Below This Line - For State Accounting's Use Only

Date Entered

Initials