ELECTRONIC FUNDS TRANSFER (EFT) INSTRUCTION

Electronic Funds Transfer (EFT) is the required payment method to deposit funds for claims approved for payment directly into a provider's bank account. These funds can be credited to either checking or savings accounts. EFT avoids the risks associated with mailing and handling paper checks; *ensuring funds are directly deposited into a specified account.*

The following notification is provided in compliance with Automated Clearing House (ACH) guidelines:

> "Most receiving depository financial institutions receive credit entries on the day before the effective date, and these funds are routinely made available to their depositors as of the opening of business on the effective date. The effective date for EFT under the Oklahoma Medicaid Program is Wednesday (or Thursday) of each week.
>
> However, due to geographic factors, some receiving depository financial institutions do not receive their credit entries until the morning of the effective day and the internal records of these financial institutions will not be updated. As a result, tellers, bookkeepers or automated teller machines (ATMs) may not be aware of the deposit and the customer's withdrawal request maybe refused. When this occurs, the customer or company should discuss the situation with the ACH coordinator of their institution who, in turn should work out the best way to serve their customer's needs.
>
> In all cases, credits received should be posted to the customer's account on the effective date and thus be made available to cover checks or debits that are presented for payment on the effective date."

Complete the Electronic Funds Transfer Authorization Agreement and attach a voided check. If a check is not available, attach a letter from your financial institution indicating the bank transit routing and account number. The document must be on bank letter head and signed by a bank official. **Deposit slips are not acceptable.**

Mail Completed Form to:

Oklahoma Health Care Authority
Attention: Provider Enrollment
Post Office Box 54015
Oklahoma City, OK 73154

Contact Information:

- ***Provider Enrollment, Fee for Service*** (800)522-0114, option 5 or local (405)522-6205, option 5.
- ***SoonerCare*** , please contact your provider representative directly.
- **Website address**, www.okhca.org.

For OHCA use only	
DE: _____	V: _____
Date: _____	Date: _____

STATE OF OKLAHOMA
ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

Complete all sections below. A voided check must be attached to the completed EFT Authorization Agreement. If a check is not available attach a letter from your financial institution indicating the bank transit routing and account number. The document must be on bank letter head and signed by a bank official. **Deposit slips are not acceptable.**

NOTICE

- EFT and Tax ID payments must be reported to the same individual or business.
- If you are an individual provider and your payments report to a Group FEIN and EFT, please complete Group Appendix A instead of EFT.

Type of Authorization: *(Check one)*

- ☐ New Enrollment or Additional Location
- ☐ Change Account Number for Financial Institution
- ☐ Correct Account or Bank Transit Number
- ☐ Change of ownership *(must also complete a new enrollment packet)*
- ☐ Change in employment, group association, practice, business structure, billing agent, tax ID, etc..., please consult Provider Enrollment for Fee for Service contract or provider representative for SoonerCare contract. *(See contact information on EFT Instruction, page 1.)*

Provider Information

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ _____
Provider ID *(One number per form. If new leave blank)* Provider Name

_____ _____ _____ _____
Service Location Address City State Zip

_____ (_____)_____
Contact Name Contact Phone Number

Financial Institution Information

Financial Institution:	Phone Number: ( )
Transit Routing number:	Account Number:
Type of Account: *(Check one)* ☐ Checking ☐ Savings	

OHCA Information

Agency Name: Oklahoma Health Care Authority	Agency Number: 807

I hereby authorize the State of Oklahoma Treasury, hereinafter called Treasury, to initiate credit entries for the checking or savings account indicated on the voided check and the financial institution named above, hereinafter called depository, to credit any amount(s) due to this medical provider by the State of Oklahoma. This authority is to remain in full force and effect until Treasury has received written notification from this provider of its termination in such time and manner as to afford Treasury and depository a reasonable opportunity to act on it.

Signature *(Individual provider must sign personally.)*

Individual	_____ _____ Provider Signature Date
Entity/Business	**CERTIFICATION** I hereby certify that I have the authority to enter into this agreement or initiate this action on behalf of the above-named entity. I further understand and acknowledge that it is unlawful to make a claim knowing the claim to be false and that such false claims is deemed Medicaid fraud under Title 56 § 1005;1006. _____ _____ _____ Print Authorized Represenative Name Signature Date