STATE OF ARIZONA – ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Electronic Funds Transfer (EFT) Authorization Agreement Instructions

Attn: AHCCCS Finance- MD 5400, P.O. Box 25520, Phoenix, AZ 85002

SECTION 1	**PROVIDER INFORMATION**			
	Provider Name		Complete legal name of institution, corporate entity, practice or individual provider	Required
	Doing Business As Name (DBA)		The trade name, or fictitious business name, under which the business or operation is conducted and presented to the world is not the legal name, the legal person (or persons) who actually own it and are responsible for it	Optional
	Provider Address			
		Street	The number and street name where a person or organization can be found	Required
		City	City associated with provider address field	Required
		State/Province	2 Character Code associated with the State/Province/Region of the applicable Country	Required
		Zip Code/ Postal Code	5 or 15 Character Code	Required
SECTION 1	**PROVIDER IDENTIFIERS INFORMATION**			
	Provider Identifiers			
		Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	A Federal Tax Identification Number also known as an Employer Idenfication Number (EIN) used to identify a business entity; Numeric, 9 digits	Required
		National Provider Identifier (NPI)	A Health Insurance Poratbilty Accountabilty Act (HIPAA) - Required when provider has been enumerated with an NPI; Numeric, 10 digits	Optional
		Trading Partner ID	AHCCCS Povider ID; 6 digits- 2 digits	Required
SECTION 2	**PROVIDER CONTACT INFORMATION**			
	Provider Contact Name		Name of a contact in provider office for handling EFT issues	Required
		Title		Optional
		Tel Number	Number associated with contact person; Numeric, 10 digits	Required
		Tel Number Ext		Optional
		Email Address	An electronic mail address at which AHCCCS might contact the provider	Required, may not have one
		Fax Number	A number at which the provider can be sent facsimiles	Optional
SECTION 3	**PROVIDER AGENT INFORMATION - IF APPLICABLE**			
	Provider Agent Name		Name of provider's authorized agent	Required
	Agent Address			
		Street	The number and street name where a person or organization can be found	Required
		City	City associated with provider address field	Required
		State/Province	2 Character Code associated with the State	Required
		Zip Code/Postal Code	5 or 15 Character Code	Required
	Provider Agent Contact Name		Name of a contact in agent office for handling EFT issues	Required
		Tel Number	Number associated with contact person; Numeric, 10 digits	Required
		Tel Number Ext		Optional
		Email Address	An electronic mail address at which AHCCCS might contact the provider	Required, may not have one
		Fax Number	A number at which the provider can be sent facsimiles	Optional
SECTION 4	**FINANCIAL INSTITUTION INFORMATION**			
	Financial Institution Name		Official name of the provider's financial institution	
	Financial Institution Address			
		Street	Street address associated with receiving depository financial institution name field	Required
		City	City associated with receiving depository financial institution address field	Required
		State/Province	2 Character Code associated with the State	Required
		Zip Code/Postal Code	5 or 15 Character Code	
		Tel Number	A contact telephone number at the provider's bank	Optional
		Tel Number Ext		Optional
	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	Required
	Type of Account at Financial Institution		The type of account the provider will use to receive EFT payments, e.g., Checking, Saving	Required
	Provider's Account Number with Financial Institution		Provider's account number at the financial institution to which EFT payments are to be deposited	Required
	Account Number Linkage to Provider Identifier		Provider preference for grouping (bulking) claim payments – must match preference for v5010 X12 835 remittance advice	Required, select from one of the two below
		Provider Federal Tax Identification Number (TIN)	Numeric, 9 digits	Optional – required if NPI is not applicable
		or		
		National Provider Identifier (NPI)	Numeric, 10 digits	Optional – required if TIN is not applicable

SECTION 5	**SUBMISSION INFORMATION**			
	Reason for Submission			
		New Enrollment		Required
		Change Enrollment		Required
		Cancel Enrollment		Required
	Include with Enrollment Submission			
		Voided Check	A voided check is attached to provide confirmation of identification/account numbers	Required
		or		
		Bank Letter	A letter on bank letterhead that formally certifies the account owners routing and account numbers	Required
SECTION 6	**AUTHORIZATION**			
	Authorized Signature		The signature of an individual authorized by the provider or its agent to initiate modify or terminate an enrollment.	Required
		Print Name of Authorized Signer	The printed name of the person submitting the form	Required
		Title	The title of person signing the form	Optional
	Submission Date		The date on which the enrollment is submitted - CCYYMMDD	Required
	Requested EFT Start/Change/Cancel Date		The date on which the requested action is to begin - CCYYMMDD	Required