Payment Method Authorization Agreement

Provider Name **Provider Number**

Choose one of the following payment methods:

- If you are an individual or group provider who will receive direct payment from Medicaid, complete **Option 1, Electronic Funds Transfer (EFT)**.
- If you are an individual who will NOT receive direct payment from Medicaid, skip Option 1 and complete **Option 2, Electronic Funds Transfer Exception**, to assign your payment to a group provider.
- If you work for a group AND will also bill separately for yourself, complete Option 1 entering your individual banking information. *Do not place an employer's information on your individual file.*

Option 1. Electronic Funds Transfer (EFT) Agreement:

The undersigned authorize the fiscal agent for the Florida Medicaid Program to make deposits to the checking or savings account at the depository bank indicated. A letter from the bank on bank letterhead verifying the bank transit / ABA routing number, the account number and account name must be attached to this form.

Name On Bank Account		**Bank Account Number**
Bank Name	**Branch**	**Bank Telephone #** ( )
City	**State**	**Zip Code**

List all individuals authorized to sign on this account:

***Note*: All individuals listed here must meet Medicaid Enrollment Background Screening Requirements. If this agreement is for an individual provider number, the individual who owns the number MUST sign here. Any future changes to this EFT account will require a signature of an individual authorized as listed below.**

Print Name	**Signature**
Bruce Gillander, Director, Division of Treasury	
Kimberly McMurray, Chief, Bureau of Funds Management	

Option 2. Electronic Funds Transfer (EFT) Agreement Exception:

I work under group provider number _____ and all disbursements made for services performed by myself will be made directly to the group on my behalf. I understand that by requesting this exemption, I will not be able to receive direct disbursements from Medicaid for the services I render, and I will not be able to file Medicaid claims under my individual provider number.

Signature of Applicant	**Title**
Print Name of Applicant	**Date**

Visit the fiscal agent web site for electronic versions of all enrollment forms: http://floridamedicaid.acs-inc.com