North Carolina Medicaid Electronic Funds Transfer (EFT)
Authorization Agreement for Automatic Deposits

At the request of North Carolina Medicaid, HP Enterprise Services, provides payment to Medicaid Providers, via Electronic Funds Transfer (EFT). This is the only option for payment. The EFT service enables you to receive payments through automatic deposit to the Medicaid Provider's bank. This process assists Medicaid Providers with receiving payments in a timely manner.

To ensure timely and accurate enrollment in the EFT program, please fill out the form on the following page, attach a voided check (not a deposit slip, starter check, or counter check) and return them by mail, fax, or email. You must include your NC Medicaid Billing Provider Number on the form.

Email to:

NCXIXEFT@hp.com

Fax to:

919-816-3186 or 919-816-4399
Attn: Finance Dept. – EFT

Mail to:

HP Enterprise Services
Finance Department
4905 Waters Edge Drive
Raleigh, NC 27606

In addition, we strongly recommend that you check the routing and account number with your bank to confirm that it is accurate and will not result in an EFT return.

Once the form is processed, payments will be electronically deposited directly to the Medicaid Provider's bank account one business day after the checkwrite day.

Thank you for your cooperation.

HP Enterprise Services Provider Services
North Carolina Medicaid
Phone: 1-800-688-6696

North Carolina Medicaid

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Request type (<u>must</u> be checked) ☐ Initial Request (Start) ☐ Change Request (Close & Start) ☐ Cancel Request (Closing)

I hereby certify that the checking OR savings accounts indicated on this form are under my direct control and access; therefore, I authorize HP Enterprise Services, as fiscal agent for the State of North Carolina, to initiate, change or cancel credit entries to those checking or savings account(s) as indicated on this form. *This authority is to remain in full force and effect until HP Enterprise Services has received written notification, from either myself or a verifiable Officer of the Agency, of the account's termination in such time and in such a manner as to afford HP Enterprise Services a reasonable opportunity to act upon it.*

MEDICAID BILLING PROVIDER NUMBER (REQUIRED)________________

***EACH PROVIDER NUMBER REQUIRES A SEPARATE REQUEST**

PROVIDER/FACILITY:____

NPI NUMBER (OPTIONAL)____

PRINTED NAME __________________________ DATE: __________________

SIGNATURE: ____

IF YOU ARE A PROVIDER <u>CHANGING FROM</u> AN EXISTING DIRECT DEPOSIT ACCOUNT OR <u>CLOSING AN ACCOUNT</u> FOR ANY REASON, COMPLETE THIS SECTION:

ACCOUNT ON FILE PRIOR TO CHANGE

BANK NAME: ____

BRANCH ADDRESS: ____

CITY:__________________________ STATE:_______ ZIP CODE:__________

BANK TRANSIT/ABA NO:____

ACCOUNT NO:____

CHECKING OR SAVINGS ____

In order for HP Enterprise Services to either change or close an account established to receive funds from North Carolina Division of Medical Assistance or North Carolina Division of Mental Health, all information above MUST be provided.

IF YOU ARE A PROVIDER <u>STARTING</u> DIRECT DEPOSIT OR <u>CHANGING</u> YOUR DIRECT DEPOSIT ACCOUNT, COMPLETE THIS SECTION:

BANK NAME:____

BRANCH ADDRESS:____

CITY:______________________ STATE:_______ ZIP CODE:________

BANK TRANSIT/ABA NO:____________________________________

ACCOUNT NO:____

CHECKING OR SAVINGS ____________________________________

Under penalties of perjury, we hereby certify the checking or savings account(s) indicated above is/are under our direct control and access. Therefore, we authorize Electronic Data Systems to initiate, change or cancel credit entries to those checking or savings account(s) and the bank name(s) as indicated above.

Please list the contact name, telephone number and exact street address responsible for completion of this form. **PO Boxes will be not be accepted.**

PROVIDER CONTACT NAME:__________________________________

CONTACT TELEPHONE NUMBER:______________________________

PROVIDER STREET ADDRESS:________________________________

CITY______________ ________ STATE___________ ZIP _________ _______

<u>A VOIDED CHECK OR OFFICIAL BANK LETTER VERIFYING ACCOUNT NAME, ACCOUNT NUMBER, ROUTING NUMBER AND ACCOUNT TYPE MUST BE ATTACHED FOR EACH BANK ACCOUNT IN ORDER TO PROCESS DIRECT DEPOSIT REQUESTS.</u>

<u>DO NOT SUBMIT DEPOSIT SLIPS, COUNTER CHECKS LACKING PRE-PRINTED INFORMATION, PERSONAL LETTERS OR PROVIDER LETTERS (UNLESS REQUESTED).</u>