

# Instructions for Completing Paper Electronic Funds Transfer (EFT) Enrollment Application

## General Instructions for completing the Paper EFT Enrollment Application:

- Please type or print legibly
- Complete all fields – **Incomplete applications will not be processed**
- Use only black or blue ink to complete the application
- Please allow four (4) weeks for new enrollment and change enrollment requests. This four week process includes a pre notification verification process to confirm EFT setup accuracy. If after four (4) weeks you do not start receiving EFT payments, please contact the Provider Assistance Center (PAC) at 1-800-248-2152.

## **Mail completed enrollment form to:**

**HPE BDCM PAMMIS  
EFT Application, MS 2-200  
1250 Camp Hill Bypass, Suite 100  
Camp Hill, PA 17011-3700**

The electronic EFT enrollment application can be completed by going to the PA PROMIS<sup>e</sup>™ Internet Portal at [www.promise.dpw.state.pa.us](http://www.promise.dpw.state.pa.us). On the Login page click the EFT/ERA Enrollment tab.

## Provider Information:

**Provider Name:** Please provide the complete legal name of the institution, corporate entity, practice, or individual provider.

## Provider Address:

**Street:** Please provide the provider's payment address.

**City:** Please provide the provider's city associated with the payment address.

**State:** Please provide the two (2) character code associated with the state name.

**Zip Code/Postal Code:** Please provide the five (5) or nine (9) digit assigned zip code from the Post Office.

## Provider Identifiers:

**Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):** Please provide your Provider identification number used to identify the business entity.

**National Provider Identifier (NPI):** Please provide the federally assigned ten (10) digit number for covered Health Care Providers.

## Other Identifiers:

**Assigning Authority:** PA PROMIS<sup>e</sup>™: Pennsylvania Medicaid.

**Trading Partner ID:** Please provide the assigned thirteen (13) digit Medical Assistance Identification Number. Multiple locations may be included on a single enrollment form. For larger entities please attach a separate sheet listing all locations to be set up.

Example: Provider Number    Service Location    Service Location    Service Location    Service Location  
0001112220001            0002                    0003                    0004                    0005

**Provider Contact Information:**

**Provider Contact Name:** Please provide the name of the provider contact for any EFT issues.

**Telephone Number:** Please provide the telephone number including area code and if applicable extension number of the provider contact.

**Email Address:** Please provide the electronic mailing address to send the provider contact correspondence.

**Financial Institution Information:**

**Financial Institution Name:** Please provide the name of the provider’s financial institution (i.e. Bank Name).

**Financial Institution Address:** Please provide the street address of the provider’s financial institution.

**City:** Please provide the name of the city associated with the financial institution address field.

**State/Province:** Please provide the two (2) character code associated with the state name.

**Zip Code/Postal Code:** Please provide the five (5) or nine (9) digit assigned zip code from the Post Office.

**Financial Institution Routing Number:** Please provide the nine (9) digit identifier for the financial institution.

**Type of Account at Financial Institution:** Please indicate the account type to which the EFT payments are to be deposited. Please only select one.

**Provider Account Number with Financial Institution:** Please provide the account number at the financial institution to which the EFT payments are to be deposited.

**Account Number Linkage to Provider Identifier:** Please select the preference for grouping (bulking) claim payments. The information in this field is collected for information purposes only. PA PROMIS<sup>e</sup>™ does **NOT** group (bulk) payments.

**Submission Information:**

**Reason for Submission:** Please select one from the list. New Enrollment will allow the provider to enroll for EFT payments. Change Enrollment will allow the provider to change existing EFT. Cancel Enrollment will allow the provider to permanently terminate the EFT.

**Include with Enrollment Submission:** A voided check **OR** bank letter must be included with the enrollment submission. If a bank letter is selected, it must be submitted on the banks official letterhead and should clearly indicate the owners account and routing number.

**Authorized Signature:** This is the signature of the individual authorized by the provider or their agent to initiate, modify, or terminate an EFT enrollment.

**Written Signature:** This would be a rendering signature (usually cursive) of a name unique to a particular person used as confirmation of authorization and identity.

**Printed Name of Person Submitting Enrollment:** This is the printed name of the person signing this form who is authorized by the provider or their agent to initiate, modify or terminate an EFT enrollment.

**Printed Title of Person Submitting Enrollment:** This is the printed title of the person signing this form who is authorized by the provider or their agent to initiate, modify, or terminate an EFT enrollment.

**Submission Date:** The date on which the EFT enrollment is submitted.

**Requested EFT Start/Change/Cancel Date:** The date on which the requested action is to begin.

For questions about this form, please call the Provider Assistance Center (PAC) at 1-800-248-2152 or send an email to [papac1@hp.com](mailto:papac1@hp.com).

The provider must contact their financial institution to arrange for the delivery of the addenda record available to assist with re-associating the payment to the electronic remittance advice. The addenda record can also be used to re-associate the EFT payment to the paper remittance advice. For more information, please access the following link:

[http://www.dhs.state.pa.us/cs/groups/webcontent/documents/communication/p\\_039799.pdf](http://www.dhs.state.pa.us/cs/groups/webcontent/documents/communication/p_039799.pdf)

**Missing/Late EFT Files:**

- **If receiving an Electronic Remittance Advice (ERA) – EFT payment will be delivered within four (4) business days of ERA issuance.**
- **If receiving paper remittance advice – EFT payment will be delivered within ten (10) business days of paper remittance advice issuance.**

**If you have not received your payment as schedule above, please contact the Provider Assistance Center (PAC) at 1-800-248-2152.**

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**pennsylvania**

DEPARTMENT OF HUMAN SERVICES

**Office of Medical Assistance Programs**

**Electronic Funds Transfer (EFT) Enrollment Application**

**Provider Information**

Provider Name \_\_\_\_\_  
Provider Address \_\_\_\_\_  
Street \_\_\_\_\_  
*(Payment Address)*  
City \_\_\_\_\_  
State/Province \_\_\_\_\_ ZIP Code/Postal Code \_\_\_\_\_

**Provider Identifiers**

Provider Identifiers  
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) \_\_\_\_\_  
National Provider Identifier (NPI) \_\_\_\_\_

**Other Identifier**

Assigning Authority **PA PROMISE™**  
Trading Partner ID \_\_\_\_\_  
*(13-digit Provider ID, plus any additional 4-digit Service Locations)*

**Provider Contact Information**

Provider Contact Name \_\_\_\_\_  
Telephone Number \_\_\_\_\_ Telephone Number Extension \_\_\_\_\_  
Email Address \_\_\_\_\_

**Financial Institution Information**

Financial Institution Name \_\_\_\_\_  
Financial Institution Address  
Street \_\_\_\_\_  
City \_\_\_\_\_  
State/Province \_\_\_\_\_ ZIP Code/Postal Code \_\_\_\_\_

Financial Institution Routing Number \_\_\_\_\_

Type of Account at Financial Institution **(Choose one)**

Checking       Savings

Provider's Account Number with Financial Institution \_\_\_\_\_

Account Number Linkage to Provider Identifier  
**(Specify TIN or NPI; linkage will not change grouping of payments by PROMISE™.)**

Provider Tax Identification Number (TIN): \_\_\_\_\_

National Provider Identifier (NPI): \_\_\_\_\_

**Submission Information**

Reason for Submission **(Choose one)**

New Enrollment

Change Enrollment

Cancel Enrollment

Include with Enrollment Submission **(Choose one)**

Voided Check

Bank Letter

**Authorized Signature**

\_\_\_\_\_  
**Written Signature of Person Submitting Enrollment**

\_\_\_\_\_  
**Printed Name of Person Submitting Enrollment**

\_\_\_\_\_  
**Printed Title of Person Submitting Enrollment**

Submission Date \_\_\_\_\_ *(format: CCYYMMDD)*

**Mail completed enrollment form to:**

**HPE BDCM PAMMIS  
EFT Application, MS 2-200  
1250 Camp Hill Bypass, Suite 100  
Camp Hill, PA 17011-3700**