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:

> **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*e*™ Internet Portal at https://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*e*™: 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

        <u>0001112220001</u>   <u>0002</u>   <u>0003</u>   <u>0004</u>   <u>0005</u>

<u>Provider Contact Information:</u>

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.

<u>Financial Institution Information:</u>

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*e*™ does **NOT** group (bulk) payments.

<u>Submission Information:</u>

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

Include with Enrollment Submission: A voided check **OR** bank letter <u>must be</u> 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.

<u>Authorized Signature:</u> 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@gainwelltechnologies.com.](mailto:papac1@gainwelltechnologies.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:

https://www.dhs.pa.gov/providers/Quick-Tips/Documents/Qtip%20166.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.

This page intentionally left blank

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 PROMIS*e*™**

    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 PROMIS*e™.)*

_____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:

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