Please note. This document has been formatted for use with screen readers. Page references in this document—whether in the table of contents or elsewhere in the text—refer to page numbers in the original publication.

Commonwealth of Massachusetts  
Executive Office of Health and Human Services  
www.mass.gov/masshealth

Electronic Funds Transfer Enrollment/Modification Form

Complete this form to enroll in electronic funds transfer with MassHealth or to terminate or modify an existing electronic funds agreement; additional terms of agreement on page 2 of this form must be completed.

**Provider Information**

Provider legal name

DBA name

Street

City

State

Zip

**Provider Identifiers Information**

Provider TIN or EIN

NPI

**Provider contact Information**

Provider contact name

Tel.

Tel. Ext.

Email

**Federal agency information**

Federal program agency identifier

**Financial Institution information**

Financial institution name

Street

City

State

Zip

Financial institution routing number

Type of account at financial institution

Provider’s account number with financial institution

Provider TIN

NPI

**Submission information**

Reason for submission

New enrollment

Change enrollment

Cancel enrollment

Included

Voided check

Bank letter

Signature of person submitting enrollment

Printed name of person submitting enrollment

Submission date

If you are modifying/changing your bank account information, you must include your old bank account information on page 2 of this form or your request will be incomplete.

Please complete page 2 in its entirety.

If you are modifying your bank account information please provide the old bank account information directly below.

Provider old bank account number:  
Account type  
Checking  
Savings

## CERTIFICATION

I,  
hereby certify that the account/s indicated on this form is under my direct control and access; therefore, I authorize the state treasurer as fiscal agent for the State of Massachusetts to initiate, change or cancel credit entries to that account/s as indicated on this form. For ACH debits consistent with the International ACH Transaction (IAT) rules check one:

I affirm that payments authorized hereunder are not to an account that is subject to being transferred to a foreign bank account.

I affirm that payments authorized hereunder are to an account that is subject to being transferred to a foreign bank account.

This authority is to remain in full force and effect until the Office of Comptroller has received written notification, from either me or an authorized officer of organization of the account's termination in such time and in such a manner as to afford CTR a reasonable opportunity to act upon it.

This authorization will remain in effect until either canceled in writing or an updated form changing information is sent to the Department you currently do business with.

Signature of authorized representative

(For signature requirements please see instructions.)

• Please contact your financial institution to arrange for the delivery of the CORE (Committee on Operating Rules for Information Exchange)-required Minimum CCD+(Corporate Credit or Debit entry) data elements needed for reassociation of the payment and the Electronic Remittance Advice (ERA).

• The form can either be signed traditionally and then scanned, or it can be signed electronically using DocuSign or Adobe Sign. For electronic signatures, the signer can upload a picture of their wet signature. The typed text of a signature is not an acceptable form of an electronic signature.

• Instructions to complete the EFT Enrollment/Modification form can be found at www.mass.gov/how-to/tips-for-completing-the-electronic-funds-transfer-eft-form. You may also confirm the status of your EFT enrollment by contacting MassHealth at (800) 841-2900, TDD/TTY: 711.

• The EFT user job aid that explains how providers can match the EFT payment to the remittance advice can be found at https://massfinance.state.ma.us/VendorWeb/JobAidTraining/MassHealth.pdf.

• The EFT Enrollment/Modification form can be completed manually or electronically. Electronic submissions must be printed, signed, faxed or mailed in the following ways.

Fax: (617) 988-8974

Mail:   
MassHealth Provider Enrollment and Credentialing   
PO Box 278   
Quincy, MA 2171-0278

End of application EFT-1