

Commonwealth of Massachusetts

Executive Office of Health and Human Services

Office of Medicaid

www.mass.gov/masshealth

# Electronic Funds Transfer (EFT) Enrollment/Modification Form

for Home- and Community-Based Services (HCBS) Waivers

and Money Follows the Person Demonstration

Complete this form to enroll in electronic funds transfer (EFT) 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 or 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 Commonwealth 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 of the following.)

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

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foreign bank account.

This authority is to remain in full force and effect until the Office of Comptroller (CTR) has received written notification, from either me or an authorized officer of the 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 at <https://www.mass.gov/doc/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).
* Instructions to complete the EFT Enrollment/Modification form can be found at [https://www.mass.gov/doc/instructions](https://www.mass.gov/lists/eftera-enrollment). You may also confirm the status of your EFT enrollment by contacting the HCBS Provider Network Administration Unit at (855) 300-7058.
* The EFT user job aid that explains how providers may match the EFT payment to the remittance advice can be found at <https://massfinance.state.ma.us/VendorWeb/MassHealthProviderJA.asp>.
* The EFT Enrollment/Modification form can be completed manually or electronically. Electronic submissions must be printed, signed, and mailed to the address below.

Mail:

ForHealth Consulting at University of Massachusetts Chan Medical School

Disability & Community Services

HCBS Provider Network Administration Unit

333 South Street

Shrewsbury, MA 01545