MassHealth

Commonwealth of Massachusetts
Executive Office of Health and Human Services
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 Code

PROVIDER IDENTIFIERS INFORMATION

Provider TIN or EIN	NPI

PROVIDER CONTACT INFORMATION

Provider Contact Name	
Telephone Number	Telephone Number Extension
E-mail Address	

FEDERAL AGENCY INFORMATION

Federal Program Agency Identifier

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name			
Street	City	State	Zip Code
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
Written 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 print double-sided whenever possible.

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

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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:

☐ 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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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 _____

- 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 www.mass.gov/eohhs/docs/masshealth/aca/eft-instructions.pdf. You may also confirm the status of your EFT enrollment by contacting the HCBS Provider Network Administration Unit at 1-855-300-7058.
- 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. The Commonwealth of Massachusetts requires a "wet" signature on all EFT enrollments, modifications, and terminations. All paper forms must be mailed to the following address:

University of Massachusetts Medical School Disability and Community Services
HCBS Provider Network Administration Unit
333 South Street
Shrewsbury, MA 01545-4169