ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Electronic Funds Transfer (EFT) Authorization Agreement Instructions

Attn: AHCCCS Finance, MD 5400, P.O. Box 25520, Phoenix, AZ 85002		
Section1: Provider Information		
Provider Name	Complete legal name of institution, corporate entity, practice or individual provider	Required
Doing Business As Name (DBA)	The trade name, or fictitious business name, under which the business or operation is conducted and presented to the world is not the legal name, the legal person (or persons) who actually own it and are responsible for it	Optional
Provider Address	The number, street name, city, two character state code, and the 5 or 15 character zip code associated with where a person or organization can be found.	Required
Section1: Provider Identifier Information		
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	A Federal Tax Identification Number also known as an Employer Identification Number (EIN) used to identify a business entity; Numeric, 9 digits	Required
National Provider Identifier (NPI)	A Health Insurance Portability Accountability Act (HIPAA) - Required when provider has been enumerated with an NPI; Numeric, 10 digits	Optional
Trading Partner ID	AHCCCS Provider ID; 6 digits - 2 digits	Required
Section 2: Provider Contact Information		
Provider Contact Name	Name of a contact in provider office for handling EFT issues	Required
Title		Optional
Tel Number	Number associated with contact person; Numeric, 10 digits	Required
Tel Number Ext		Optional
Email Address	An electronic mail address at which AHCCCS might contact the provider	Required, may not have one
Fax Number	A number at which the provider can be sent facsimiles	Optional
Section 3: Provider Agent Information – If Applicable		
Provider Agent Name	Name of provider's authorized agent	Required
Agent Address	The number, street name, city, two character state code, and the 5 or 15 character zip code associated with where a person or organization can be found.	Required
Provider Agent Contact Name	Name of a contact in agent office for handling EFT issues	Required
Tel Number	Number associated with contact person; Numeric, 10 digits	Required
Tel Number Ext		Optional
Email Address	An electronic mail address at which AHCCCS might contact the provider	Required, may not

		have one
Fax Number	A number at which the provider can be sent facsimiles	Optional
Section 4: Financial Institution Information		
Financial Institution Name	Official name of the provider's financial institution	Required
Financial Institution Address	The number, street name, city, two character state code, and the 5 or 15 character zip code associated with receiving depository institution.	Required
Tel Number	A contact telephone number at the provider's bank	Optional
Tel Number Ext		Optional
Financial Institution Routing Number	A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited	Required
Type of Account at Financial Institution	The type of account the provider will use to receive EFT payments, e.g., Checking, Saving	Required
Provider's Account Number with Financial Institution	Provider's account number at the financial institution to which EFT payments are to be deposited	Required
Account Number Linkage to Provider Identifier	Provider preference for grouping (bulking) claim payments – must match preference for v5010 X12 835 remittance advice	Required, select from one of the two below
Provider Federal Tax Identification Number (TIN) or	Numeric, 9 digits	Optional - required if NPI is not applicable
OR		
National Provider Identifier (NPI)	Numeric, 10 digits	Optional - required if TIN is not applicable
Section 5: Submission Information		
New Enrollment		Required
Change Enrollment		Required
Cancel Enrollment		Required
Include with Enrollment Submission		
Voided Check	A voided check is attached to provide confirmation of identification/account numbers	Required
OR		
Bank Letter	A letter on bank letterhead that formally certifies the account owners routing and account numbers	Required
Section 6: Authorization		
Authorized Signature	The signature of an individual authorized by the provider or its agent to initiate modify or terminate an enrollment.	Required

Print Name of Authorized Signer	The printed name of the person submitting the form	Required
Title	The title of person signing the form	Optional
Submission Date	The date on which the enrollment is submitted - CCYYMMDD	Required
Requested EFT Start/Change/Cancel Date	The date on which the requested action is to begin - CCYYMMDD	Required