Pennsylvania Medicaid Program
Automated Clearinghouse Enrollment Application

Complete all fields on this application and attach a voided check or a letter from your bank. **This application cannot be processed if submitted without a voided check or letter from bank on bank letterhead.**

Provider Name ___________________________ Provider MAID Number _____________________
(9 digits)

Service Location's: _____________ _____________ _____________ _____________
(4 digits each location) (Additional service locations can be listed on the following sheet)

Contact Name ____

Contact Phone Number ____

ABA Transit Routing Number ____

Name of Bank Receiving Deposit ____

Provider Bank Account Number ____

Type of Authorization ☐Start ☐Cancel ☐Change

Type of Account ☐Checking ☐Savings

I hereby authorize the Commonwealth of Pennsylvania to post payments into the financial account referenced above. I understand that I am responsible for the validity of the information on this form. If the ACH transmission fails, I would like payment by check to be mailed to the following address below:

<u>Payment Address:</u>

Street __________________________________

City and State __________________________________

Zip Code __________________________________

____ ______________________________

Signature of Authorized Party Date

Mail Application To: Automated Clearinghouse Unit
HP Enterprise Services
225 Grandview Ave
Mail Stop A-20
Camp Hill, PA 17011

Or FAX To: (717) 975-4270

Phone: (717) 975-4100
(800) 248-2152

Additional Service Locations (if necessary)

(4 digits each location)