Electronic Funds Transfer Agreement

Providers who receive payment of claims by Managed Health Services (MHS) must agree to the following terms and conditions:

1. **EFT Information**. Provider will submit EFT information noted below that includes the name of the entity listed on your W-9 ("Payee"), name of the bank, bank routing number, bank account number to which funds will be transferred. Provider will notify MHS in writing at least ten (10) days in advance of any changes in Payee, Payee's name or address, or bank account name or number.

2. **Non-Provider Payee**. If the Payee indicated on the EFT information below is different from the contracted Provider and/or Group Practice, Provider must submit to MHS a signed and notarized Power of Attorney for Payee. Designation of a Payee other than Provider shall not relieve Provider of any liability for acceptance of medical assistance payments under the Medicaid program. Provider acknowledges and agrees that Payee is not an individual or organization, such as a collection agency or service bureau, that advances money based on future Medicaid payments (accounts receivable) due to Provider after agreeing to sell, transfer or assign such rights to payment to the individual or organization for an added fee or a percentage of the accounts receivable. Any payments to the Payee shall be related to the cost of processing, and shall not be based on the percentage of amounts paid or upon collection of the payments.

3. **Payment of Funds**. Provider authorizes MHS to credit and debit the proper account to Payee's bank pursuant to an EFT and is sufficient to show acceptance of payments. Provider certifies by such acceptance that Provider submitted the claims for the services shown on the explanation of payment issued by MHS, and that the services were rendered by or under the supervision of Provider. MHS may elect for good cause to substitute payment by paper check for EFT until the cause requiring the substitution has been satisfied as determined by the MHS. Payment by check will be made to the address for payments on record with MHS.

4. **Termination.** Breach of these terms may cause termination of EFT by MHS. Provider's termination of network participation for any reason will terminate EFT automatically.

______________________________________ ____________________

Signature of Provider or Administrator Date

Electronic Funds Transfer Agreement

Payee Name:______________________________

Payee Phone Number:______________________________

IRS#:______________________________

Bank Name:______________________________

Bank Address:______________________________

Bank City, State & Zip:______________________________

Bank Routing #:______________ Bank Account #:______________

EFT

- ☐ Yes, please send electronic funds transfer to the account listed above.
- ☐ No, please send a paper check.

835

- ☐ Yes, please send electronic explanation of payment.

  Clearinghouse Name: ______________________

  Clearinghouse ID#: ______________________

  Sender/Receiver ID: ______________________ (direct claim submitters only)

  Technical Contact Name: ______________ Phone #: ____________

- ☐ No, please do not send an electronic explanation of payment.

Remit

- ☐ Yes, please send a paper copy of the explanation of payment.
- ☐ No, please do not send a paper copy of the explanation of payment.

If you answer **Yes** to both "835" and "Remit," the paper copy will discontinue after 60 days.

Return this form to: Managed Health Services, Provider Relations Dept.
10700 W. Research Dr. Suite 300
Milwaukee, WI 53226
FAX: 1-800-789-3843

For Internal Use Only:

MHS rcvd:	Payee #:	Finance:	MHS:

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