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VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Vermont Medicaid Electronic Funds Transfer Request Form

Provider Information (Completion Required)

Provider Name: _____

Provider Tax Identification Number (TIN) or Employer Identification Number (EIN): _____

National Provider Identifier (NPI), if applicable: _____

Assigning Authority (VT Medicaid Provider #): _____

Provider Taxonomy Code: _____

Provider Contact Information (Name of a contact in the provider's office for handling EFT issues – Completion Required)

Provider Contact Name: _____

Email Address: _____ Phone #: _____

Billing Agent Information (Completion of this section is optional and does not apply to all providers)

The following section must be completed if the EFT for the provider named on this document will be sent to a bank account belonging to a billing agent and not the bank account of the provider. The exception for a business agent is limited to agents who furnish statements and receive payments in the name of the provider, and the service provided by the agent is: (1) related to the cost of processing the bill; (2) not related to a percentage or other basis to the amount billed or collected; and (3) not dependent upon the collection of payment. Further, a payment for a provider may not be made to or through an individual or organization (collection agency or service bureau), or by power of attorney thereof, that advances money for accounts receivable a provider has assigned, sold, or transferred to the individual or organization for a fee or deduction of accounts receivable.

Does this account belong to a Billing Agency or Group? ☐ Yes ☐ No

If Yes, please complete the below section. If no, completion is no required.

Provider Agent Name (Name of provider's authorized agent): _____

Street: _____

City: _____ State: _____ Zip Code: _____

Provider Agent Contact Name: _____

Email Address: _____ Phone #: _____

Financial Institution Information (Completion Required)

Financial Institution Name: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Type of Account at Financial Institution: ☐ Checking ☐ Savings

Financial Institution Routing Number: _____

Provider's Account Number with Financial Institution: _____

Submission Information (Completion Required)

Reason for Submission: ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

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Clarification: A Taxpayer Identification Number (TIN) is an identification number used by the Internal Revenue Service (IRS) in the administration of tax laws. It is issued either by the Social Security Administration (SSA) or by the IRS. A Social Security number (SSN) is issued by the SSA whereas all other TINs are issued by the IRS. An atypical provider not eligible for enumeration by an NPI must supply its EIN/TIN.

Required for New Enrollment and Change Enrollment: Please include one of the following documents with this form for verification of account owner and account number:

1. a pre-printed voided check
   or
2. a signed letter from your bank that lists the account holder's name, and the appropriate financial institution's account and routing numbers.

*This EFT Change Request Form will not be processed until Gainwell can validate the authenticity of the request, which will include direct outreach to the provider/entity for which the change will impact.

NOTE: This EFT will not take effect until we are able to TEST with the bank to verify the accuracy of the information provided. A MOCK DEPOSIT WILL BE EXECUTED ONLY IF YOU BILL US. After a successful $0 deposit, we will start depositing money into the financial institutions account number specified above.

I agree to keep, and disclose upon request to authorized agencies, records which disclose fully the extent of payments claimed from and services rendered to recipients of Medicaid. I accept as payment in full the amount paid by Medicaid for claims submitted with the exception of authorized cost sharing by recipients. I understand payment of this claim is from state and federal funds and that any false claims, statements, documents or concealment of a material fact may be prosecuted under state or federal law. This is to certify that the information submitted to obtain this payment is true, accurate and complete. I authorize the electronic transfer of Vermont Medicaid payments made to the above provider number. I understand that I am responsible for the validity of the above information.

Authorized Signature: _____ Date: _____

Printed Name of Person Submitting: _____

If this is a new account, please indicate the earliest date for EFT processing: _____

Please return completed form(s) to:
Gainwell Technologies
Attn: Provider Enrollment
PO Box 888
Williston, VT 05495

Fax to: 802.433.4199

For Internal Use Only

EFT Status: _____ Date Submitted: _____

Date Verified: _____ Test Dates: _____