



DIRECT DEPOSIT AUTHORIZATION / AGREEMENT FORM

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Make one copy of this form for your records and mail original form with a copy of a voided check for the account to:

Mississippi Medicaid Program

Provider Enrollment

P.O. Box 23078

Jackson, Mississippi 39225

NOTE: Because of the Federal Cash Management Act, it is necessary for the Division of Medicaid to mandate the Direct Deposit of Medicaid payments to all Medicaid providers. With the weekly average Medicaid provider payments exceeding \$20 million, without Direct Deposit the interest to the Federal government would have to be paid from all State funds that would otherwise be used to match federal funds to make provider payments. Given Mississippi's favorable federal match rate, this would have the potential of reducing total program dollars by more than \$10 million per year. This process has been underway since October 26, 1992 and has proven to be beneficial to both the State of Mississippi and the Medicaid providers. Please complete this form in order for us to complete your enrollment process and begin depositing your funds electronically. **Alert: If you choose not to complete this agreement you will not be assigned a Mississippi Medicaid Provider Number.**

You may contact Mississippi's Provider Relations Unit at 1-800-884-3222, Monday-Friday 8AM-5PM CST if you have any questions about the Direct Deposit Authorization/Agreement Form or wish to inquire upon the status of a form that has already been submitted.

Attention! It is the Provider's responsibility to contact their financial institutions to arrange for delivery of the CCD+ (addenda detail record) data elements needed for re-association of the payment and the ERA.

Instructions for filling out this form are provided at the end. Required fields are denoted with an asterisk(*).

Provider Information

Provider Name*

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN)*
or Employer Identification Number (EIN)

National Provider Identifier (NPI)*

Provider Contact Information

Provider Contact Name

Title

Telephone Number

Telephone Number Extension

Email address

Fax Number

Financial Institution Information

Financial Institution Name*

Financial Institution Address

Street

City

State

Zip

Financial Institution Routing Number*



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Type of Account at Financial Institution*

Checking

Savings

Provider's Account Number with Financial Institution*

Account Number Linkage to Provider Identifier*
(Must Match ERA Preference)

Provider Tax Identification Number (EIN/TIN)

National Provider Identification Number (NPI)

Submission Information

Reason for Submission*

New Enrollment

Change Enrollment

Cancel Enrollment

Authorized Signature

I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents; or concealment of a material fact, may be prosecuted under applicable federal or state laws. I further authorize the Mississippi Division of Medicaid to present credit entries (deposits) into the bank account referenced above and depository named above. These credits will pertain only to direct deposit transfer payments for Medicaid services that the payee has rendered. **I further understand that in the event my bank account information was to change, I must notify the Mississippi Division of Medicaid in order to change my bank account information immediately. I will not hold the Mississippi Division of Medicaid liable for presentation of any and all credit entries (deposits) into the bank account referenced above and the depository named above if I fail to notify the Division of Medicaid or the fiscal agent of my change in bank account information.**

Written Signature of Person Submitting Enrollment*

Printed Name of Person Submitting Enrollment

Submission Date



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INSTRUCTIONS
Required fields are denoted with an asterisk (*).

Provider Information

Provider Name* - If the provider is an individual, enter the provider's name. If the provider is a group, enter the group name.

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)* - Enter the Federal Tax Identification Number (TIN) or the Employer Identification Number (EIN), if available. If the provider is an individual who doesn't have a Federal Tax Identification Number (TIN), or Employer Identification Number (EIN), enter the provider's own Social Security Number in the TIN/EIN field.

National Provider Identifier (NPI)* - Enter the provider's National Provider Identifier Number. If you are a Non-Healthcare Provider without an NPI, enter 10 zeros in the NPI field.

Provider Contact Information

Provider Contact Name* - Enter the name of the person to be contacted for questions or clarification.

Title - Enter the title of the Provider Contact person.

Telephone Number - Enter the telephone number, including area code, of the Provider Contact Person.

Telephone Number Extension - Enter the telephone number extension of the Provider Contact Person, if applicable.

Email address - Enter the email address of the Provider Contact Person.

Fax Number - Enter the fax number of the Provider Contact Person.

Financial Institution Information

Financial Institution Name* - Enter the name of the financial institution that is to receive the provider's payments.

Financial Institution Address (Street) - Enter the street address of the financial institution.

Financial Institution Address (City) - Enter the city address of the financial institution.

Financial Institution Address (State) - Enter the two digit state abbreviation of the financial institution.

Financial Institution Address (Zip) - Enter the zip code address of the financial institution.

Financial Institution Routing Number* - Enter the nine digit routing number of the financial institution.

Type of Account at Financial Institution* - Check the Checking radio button if the account at the financial institution is a checking account. Check the Savings radio button if the account is a savings account.

Provider's Account Number with Financial Institution* - Enter the provider's account number with the financial institution.

Account Number Linkage to Provider Identifier* - Check the Provider Tax Identification Number (EIN/TIN) radio button if the provider is a Non-Healthcare Provider and does not have an NPI, enter 10 zeros in the NPI field.



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INSTRUCTIONS
Required fields are denoted with an asterisk (*).

Submission Information

Reason for Submission* - Check the New Enrollment radio button if this application is to enroll a new provider for EFT. Check the Change Enrollment radio button if this application is to make a change to an existing provider's EFT information. If the Cancel Enrollment radio button is checked, the cancellation will be denied since an EFT is required to be on file for all active providers.

Authorized Signature

Written Signature of Person Submitting Enrollment* - This application should be signed by the individual provider or an authorized person.

Printed Name of Person Submitting Enrollment – Enter the name of the person who signed the form to submit enrollment.

Submission Date – Enter the current date.

Missing or Late EFT Procedures

- The provider will contact the Conduent Call Center at (1-800-884-3222) to verify their banking information that is currently on file.
- The Call Center Agent will verify the banking account and routing numbers.
- If the account number is correct, the Call Center Agent will advise the provider to contact their financial institution's ACH department.
- If the banking account or routing number isn't correct, the Call Center Agent will direct the provider to update their banking account information via this Direct Deposit Authorization/Agreement form which is available on the Mississippi Medicaid website at www.ms-medicaid.com under Provider → Provider Enrollment for online submission to be downloaded.