ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Electronic Funds Transfer (EFT) Authorization Agreement

Attn: AHCCCS Finance MD 5400
P.O. Box 25520, Phoenix, AZ 85002
Fax Number: 602-258-5943

*Required Field
+Required Field If Section Is Applicable

***Select one:**

☐ **New Enrollment*** APEP Application ID:

☐ **Existing Enrollment*** AHCCCS ID:

Section 1: Provider Identifier Information	
Provider Name*	Doing Business As Name (DBA)*
Provider Address*	
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)*	National Provider Identifier (NPI)*

Section 2: Provider Contact Information Responsible for Verifying Bank Details		
Provider Contact Name*	Title*	Telephone Number & Extension*
Email Address*		Fax Number

Section 3: Provider Agent Information – If Applicable		
Provider Agent Name**+**		
Agent Address**+**		
Provider Agent Contact Name**+**	Title**+**	Telephone Number & Extension**+**
Email Address**+**	Fax Number	

Section 4: Financial Institution Information	
Financial Institution Name*	Financial Institution Telephone Number & Extension*
Financial Institution Address*	
Financial Institution Routing Number*	Type of Account at Financial Institution* ☐ Checking ☐ Savings
Provider’s Account Number with Financial Institution *	

Account Number Linkage to Provider Identifier*
Provider's Federal Tax Identification Number:
OR
National Provider Identifier Number:

Section 5: Submission Information

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

Include with Enrollment Submission*
☐ Voided Check (a voided check is attached to provide confirmation of identification/account numbers) **OR**
☐ Bank Letter (A letter on bank letterhead that formally certifies the account owners routing and account numbers

Section 6: Authorization

Pursuant to A.R.S. Sec. 35-185, I authorize the Arizona Department of Administration (ADOA, General Accounting Office (GAO) and the Arizona Health Care Cost Containment System (AHCCCS) to process payments owed to me via Automated Clearing House (ACH) deposits. The State of Arizona and AHCCCS shall deposit the ACH payments in the financial institution and account designated above.

***I recognize that if I fail to provide complete and accurate information** on this authorization form, the processing of the form may be delayed or made impossible, or my electronic payments may be erroneously made.

I authorize the State of Arizona and AHCCCS to withdraw from the designated account all amounts deposited electronically in error in accordance with NACHA rules and timelines. If the designated account is closed or has an insufficient balance to allow withdrawal, then I authorize the State of Arizona and AHCCCS to withhold any payment owed to me by the State of Arizona and AHCCCS until the erroneous deposited amounts are repaid. If I decide to change or revoke this authorization, I recognize that I must forward such notice to AHCCCS, Attn: Finance Dept., Mail Drop 5400, P.O. Box 25520, Phoenix, AZ 85002. The change or revocation is effective on the day that ADOA/GAO and AHCCCS process the request.

I certify that I have read and agree to comply with the State of Arizona and AHCCCS's rules governing payments and electronic transfers as they exist on the date of my signature on this form or as subsequently adopted, amended, or repealed. I consent to, and agree to, comply with these rules even if they conflict with this authorization form.

I authorize the State of Arizona and AHCCCS to stop making electronic transfers to my account without advance notice.

I certify that I am authorized to contract for the entity receiving deposits, pursuant to this agreement, and that all information provided is accurate.

The financial institution can process EFT payments/transactions along with addendum information.*
☐ Yes ☐ No

Authorized Signature*	Printed Name of Authorized Signer*
Submission Date*	Title
Requested EFT Start/Change/Cancel Date*	