For Fiscal Agent Use:

Florida Medicaid Electronic Funds Transfer (EFT) Authorization Agreement

Provider Information*

Provider Name*		
Doing Business As Name (D/B/A)		
Provider Address Street * *(Street Name and Number – NOT a P.O. Box)*		
Provider Address *(Suite, Room, etc.)*		
City*	State*	ZIP*

Provider Identifiers Information*

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)*	National Provider Identifier (NPI)^

Other Identifiers* Assigning Authority - Florida Medicaid

Provider Identification Number*	Trading Partner ID^

Provider Contact Information – *for EFT Issues**

Provider Contact Name*		
Telephone Number*	E-mail Address^	Fax Number

Financial Institution Information*

Financial Institution Name*		
Financial Institution Routing Number*		
Type of Account at Financial Institution*		
❑ Checking	❑ Savings	❑ Lock Box
Provider's Account Number with Financial Institution*		
Account Number Linkage to Provider Identifier* *(Must match preference submitted on ERA)*		
❑ Provider Tax Identification Number (TIN)	❑ National Provider Identifier (NPI)	
NOTE: This information is being collected in the event Florida Medicaid changes EFT linkage (which is currently done by Medicaid Provider Identification Number.)		

Submission Information*

Reason for Submission*		
❑ New Enrollment	❑ Change Enrollment	❑ Cancel Enrollment
Include with Enrollment Submission*		
❑ Voided Check	❑ Bank Letter	
Authorized Signature*		
Printed Name of Person Submitting Enrollment*		
Printed Title of Person Submitting Enrollment*	Submission Date*	

❑ Check here if you have more than one authorized signer. If checked, proceed to page 2.

For Fiscal Agent Use:

Florida Medicaid Electronic Funds Transfer (EFT) Authorization Agreement (cont.)

(Submit 2nd page only if needed for additional signatures.)

Authorized Signature*	
Printed Name of Person Submitting Enrollment*	
Printed Title of Person Submitting Enrollment*	Submission Date*

Authorized Signature*	
Printed Name of Person Submitting Enrollment*	
Printed Title of Person Submitting Enrollment*	Submission Date*

Authorized Signature*	
Printed Name of Person Submitting Enrollment*	
Printed Title of Person Submitting Enrollment*	Submission Date*

Instructions for completing the EFT Authorization Agreement

- The authorization form may be accessed via the public web portal (http://mymedicaid-florida.com) by selecting Enrollment and then Enrollment Forms. New applicants will be prompted to complete the form online as part of their Medicaid provider application.
- Type or print legibly using blue or black ink if completing the paper authorization.
- Fields marked with an asterisk (*) are required.
- Fields marked with a carat (^) are required if the information is available.
- Each person with signing privileges on the depository account should sign this form. If the account has more than four signers, attach copies of page 2 as needed.
- Attach a voided check or a letter on bank letterhead to certify the routing and account numbers.
- Please allow 3 weeks for processing. If after 3 weeks you do not receive EFT for issued payments, contact the Provider Enrollment Call Center at (800) 289-7799, Option 4 to inquire.