Washington State Health Care Authority

Authorization Agreement for Electronic Funds Transfer (EFT)

Part I

DSHS Social Service Providers Only	**ALL providers**
Please Choose One: ☐ Applies to **ALL** Social Service locations with this tax ID ☐ Applies to **ONLY** the Social Service address listed. If you are not updating all of the Social Service locations under this tax ID you will need to submit an EFT form for each location. **Note: This section must be filled out for the form to be complete.**	**Please Choose One:** ☐ New Enrollment ☐ Change Enrollment ☐ Cancel EFT Enrollment

Part II

Legal Name or Legal Organization Name (see W-9)	National Provider Identifier (NPI)
Business Name (DBA) if different from Legal Organization Name above	
Physical Street Address	Federal Tax ID: SSN/FEIN
City	Provider Name Title
State/Province Zip Code + 4	Telephone Number (with Area Code)

Part III

Financial Institution Name	Financial Institution Routing Number
☐ Checking ☐ Savings account Account Type (Will default to CCD if no option is checked) ☐ PPD (Personal) ☐ CCD (Corporate/Business)	Provider Financial Institution Account Number

Part IV

Electronic Remittance Advice (HIPAA 835). This section does not apply to DSHS Social Service Providers.

☐ EDI/835 Delivered directly to provider (*You will need a Trading Partner Agreement (TPA) – this agreement can be found at: https://www.hca.wa.gov/billers-providers-partners/forms-and-publications*.)

Part V

I hereby authorize and request Washington State to initiate credit entries to my account indicated above, and the depository named above is authorized to credit such account. If a reversal action is required, Washington State will notify the receiver of the error and give the reason for reversal. If any action taken by me, without adequate notification to Washington State, results in non-acceptance of the transfer by the designated financial institution, I understand that Washington State assumes no responsibility for processing supplemental payments until the funds are returned to Washington State by the financial institution. This authority will continue until Washington State has had a reasonable opportunity to act upon my written request to terminate EFT service or until Washington State determines that the required qualifications for enrollment are no longer being maintained.

Authorization (Print)	Title (Print)
Authorization Signature	Date Of Submission

PLEASE MAIL OR FAX FORM TO:

HCA – MEDICAID
PO BOX 45562
OLYMPIA, WA 98504-5562
FAX (360) 725-2144