MOLINA HEALTHCARE | Molina Complete Care

INSTRUCTIONS FOR COMPLETING THE ELECTRONIC FUNDS TRANSFER AGREEMENT

All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Molina Healthcare of Virginia, LLC (dba Molina Complete Care) direct deposits are made.

PART I: REASON FOR SUBMISSION

Indicate your reason for completing this form by checking the appropriate box: **New, Change or Cancel** EFT enrollment account information.

PART II: ACCOUNT HOLDER INFORMATION

- Enter the provider's/supplier's legal business name, or the name of the physician or individual practitioner, as reported to the Internal Revenue Service (IRS). The account to which EFT payments made must bear the name of the physician or individual practitioner, or the legal business name of the person or entity.
- Enter the account holder's street address.
- Enter the account holder's city, state, and zip code.
- Enter the tax identification number as reported to the IRS. If the business is a group, organization or corporation, provide the Federal employer identification number. If enrolling as an individual, provide your Social Security Number.
- Enter the 10-digit NPI number. The NPI is required to process this form.
- If issued, enter the Medicare identification number assigned by a Medicare Administrative Contractor (MAC). If you are not enrolled in Medicare, leave this field blank.

PART III: FINANCIAL INSTITUTION INFORMATION

- Enter your Financial Institution's name (this is the name of the bank or qualifying depository that will receive the funds).
  Note: The account name to which EFT payments will be paid is to the name submitted on Part II of this form.
- Enter the provider's/supplier's account number with the financial institution, including applicable leading zeros.
- Enter the financial institution's street address.
- Enter the financial institution's city or town, state or province, and zip/postal code.
- Enter the bank or financial institution's nine-digit routing number, including applicable leading zeros.
- Select the account type.

PART IV: AUTHORIZATION

- Enter the name and title of the authorized contact person who can answer questions about the information supplied on this form.
- Enter the authorized contact person's telephone number.
- Enter the authorized contact person's e-mail address.
- By your signature on this form, you are certifying that the account is drawn in the Name of the Physician or Individual Practitioner, or the Legal Business Name of the person or entity. The person or entity has sole control of the account to which EFT deposits are made.

  The EFT authorization form must be signed and dated by the Account Holder, an Authorized Representative or Delegate to include a telephone number to be contacted.

  Submit this completed form via secure email or secure fax transmittal as instructed on the form. Missing elements such a signature, date, voided check or official bank letter will result in a delay in processing or rejection of this form.

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

Please include a confirmation of account information on bank letterhead or a voided check

Note: Starter checks are not acceptable for EFT confirmations

PART I: REASON FOR SUBMISSION

Reason for Submission:

☐ **New** EFT Enrollment ☐ **Change** to Current EFT Enrollment ☐ **Cancel** Current EFT Enrollment

☐ Individual ☐ Group (e.g., account or bank changes)

PART II: ACCOUNT HOLDER INFORMATION

Provider/Supplier Legal Business Name *(if individual, please provide first name, middle initial, last name and suffix)*

_____

Account Holder's Street Address

_____

Account Holder's Telephone Number

_____

Account Holder's City State Zip Code

_____|_____|_____

Tax Identification Number (TIN)

___|___|___|___|___|___|___|___|___|___|___|

Designate TIN:

☐ SSN (enrolling as an individual) **OR**

☐ EIN (enrolling as a group/organization/corporation)

National Provider Identifier Number (NPI)

___|___|___|___|___|___|___|___|___|___|____

Medicare Identification Number *(if issued)*

_____

PART III: FINANCIAL INSTITUTION INFORMATION

Financial Institution's Name

_____

Account Number *(include all leading zeros)*

|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

Financial Institution's Street Address City/Town State/Province Zip Postal Code

_____|_____|_____|_____

Financial Institution Routing Number

(must be 9 digits—include all leading zeros)

|___|___|___|___|___|___|___|___|___|

Account Type *(check one)*

☐ Checking Account

☐ Savings Account

PART IV: AUTHORIZATION

I hereby authorize Molina Healthcare of Virginia, LLC, on behalf of itself and its affiliates, (hereinafter "Company") to initiate credit entries to the account at the financial institution listed above for all payments. I authorize and request the financial institution to accept credit entries by Company to such account and to credit the same to such account. If Company credits more money than the correct payment amounts due to duplicate electronic funds transfers (where "duplicate" is defined as multiple electronic funds transfers received for the same services rendered, the same membership, and the same dates of service) or erroneous electronic funds transfers (where "erroneous" is defined as complete electronic funds transfers received in error) I authorize Company to withdraw the overpayment electronically. I accept responsibility for any resulting loss of payment and release Company from any liability for or arising from my failure to submit accurate or updated information to Company. I understand that I must communicate any changes in my information to Company. This authorization is effective as of the signature date below and is to remain in full force and effect until Company has received written notification from me of its termination or Company notifies me that this service has been terminated. I agree to provide notification of change/termination 30 days in advance. By signing this authorization, I acknowledge that I have read and agree to the conditions set forth herein. Furthermore, I certify that the information provided is true and accurate in all respects and that I have been duly authorized to enter into this agreement.

_____

Authorized/Delegated Official Name (Print)

_____

Authorized/Delegated Official Telephone Number

_____

Authorized/Delegated Official Title

_____

Authorized/Delegated Official E-mail Address

_____

Authorized/Delegated Official Signature

_____

Date

Submit this completed form along with a voided check and/or official bank letter using one of the following options:

- Secure Fax, with subject *ATTN:EFT Enrollment*, to 1-888-656-5098
- Secure email, with subject *ATTN:EFT Enrollment*, to MCCVA-Provider@molinahealthcare.com