SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Electronic Funds Transfer (EFT) Authorization Agreement

REASON FOR SUBMISSION			
☐ **Change to Current EFT** ***(i.e. account or bank changes)***	◯ ***Individual***	◯ ***Organization***	
INDIVIDUAL PROVIDER/ORGANIZATION NFORMATION			
Individual Provider/Organization Legal Business Name			
Doing Business as Name (DBA)			
Street			
City	State	Zip Code/Postal Code	-
Medicaid Provider Number	National Provider Identifier (NPI)		
Designate Tax Identification Number (TIN)	◯ SSN (individual)	◯ EIN (organization)	
SSN	- -	EIN	-
ORGANIZATION/INIDIVIDUAL PROVIDER EFT CONTACT INFORMATION			
Provider Contact Name			
Telephone Number	Extension		
Email Address			
FINANCIAL INSTITUTION INFORMATION			
Financial Institution Name			
Financial Institution Address			
City	State	Zip Code/Postal Code	-
PROVIDER'S ACCOUNT NUMBER WITH FINANCIAL INSTITUTION			
Financial Institution Routing Number (Nine digits)			
Provider's Account Number with Financial Institution (Up to 17 digits)			
Type of Account at Financial Institution (TRANSIT CODE)	◯ 22 – Checking Account **or**	◯ 32 – Savings Account	

By signing this form, I authorize the SCDHHS to initiate credit entries, if necessary, debit entries for any credits in error to the checking or savings account at the financial institution identified above. Credit entries will pertain only to the SCDHHS payment obligations resulting from Medicaid services rendered by the provider. In the event of excess payment to this bank account, I authorize the SCDHHS to make an adjusting debit entry to the account up to the amount of the excess payment. Credit entries to the above account are done with the understanding that payment will be from federal and/or state funds and that any false claims, statements or documents or concealments of a material fact, may be prosecuted under applicable federal or state laws. I certify that the information shown is correct and agree to provide 30 days written notice to the address shown below prior to revoking or revising this authorization.

☐ **I acknowledge that I have read and understand that payments will be issued only to the bank account of the provider designated to receive payments beginning July 2019 with the transition of Medicaid claims payments to the South Carolina Enterprise Information System (SCEIS). For more information, please visit https://vip.scdhhs.gov/sceis or contact 888-289-0709.**

ALL EFT REQUESTS ARE SUBJECT TO A 10-DAY PRENOTE PERIOD IN WHICH ALL ACCOUNTS ARE VERIFIED BY THE QUALIFYING FINANCIAL INSTITUTION BEFORE ANY MEDICAID DIRECT DEPOSITS ARE MADE.

Signature of Person Submitting Form (print to sign)	
Printed Name of Person Submitting Form	
Submission Date	

SPECIAL INSTRUCTIONS: For questions regarding the status of your EFT update, please contact the Provider Service Center at 888-289-0709. Please refer to the EFT section of the provider enrollment manual found at https://www.scdhhs.gov/provider for instructions on how to complete updates to your EFT information.

Effective Jan 01, 2014, providers can link their EFT with their electronic remittance advice (ERA) by a matching EFT Reassociation Trace Number. This trace number will automatically be included in your electronic remittance advice. In order for this trace number to appear in your EFT notification, you must contact your financial institution and request the addition of this information. Any questions regarding the EFT Reassociation Trace Number and ERA can be directed to the Provider Service Center at 888-289-0709.

To process **EFT updates**, please return this completed form along with verification of your electronic deposit information on your financial institution's letterhead to:

SCDHHS, Medicaid Provider Enrollment ● PO BOX 8809 ● Columbia, South Carolina 29202-8809 ● FAX 803-870-9022