



Electronic Funds Transfer

Authorization Form

Section 1 To be Completed by Provider

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------|------------------------------------------|
| Transaction Type: | <input type="checkbox"/> New EFT | <input type="checkbox"/> Change EFT | <input type="checkbox"/> Discontinue EFT |
| Ten-Digit WV Medicaid Provider Number: | _____ | | |
| Provider Name: | _____ | | |
| Address: | _____ | | |
| City: | State: | ZIP: | |
| Telephone: | Fax: | | _____ |
| Contact Person: | Email: | | _____ |
| Comment: | _____ | | |
| Name of Financial Institution: | _____ | | |
| Address of Financial Institution: | _____ | | |
| Routing (ABA) Number: | _____ | | |
| Corporate Checking Account Number: | _____ | | |
| In signing this form, I authorize my payments to be directed to the below financial institution and designated account, or discontinued if "Discontinue EFT" is checked above. | | | |
| Signature: | Date: | | _____ |

Section 2 To be Completed by Financial Institution (for New or Change EFT)

| | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| I confirm the identity of the above-named payee and the account number and title. As a representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit payments identified above. | |
| Print Representative's Name and Title: | Telephone Number: |
| _____ | _____ |
| Signature of Representative: | Date: |
| _____ | _____ |

Return this form to the address or fax number listed above.