



Electronic Funds Transfer (EFT) Authorization Form

[ ] " Pgy 'GHV' Cwj qt k c v k q p "" [ ] " GHV' Vgt o l p c v k q p ' Tgs w g u v ' "

[ ] " W r f c v g l E j c p i g ' k p h t o c v k q p ' i q o ' e j c p i g u ' v q ' c e e q w p v ' q t ' d c p m ' "

Rt q x l f g t ' k p h t o c v k q p "

Provider Group Name: \_\_\_\_\_
DBA, if applicable: \_\_\_\_\_
Tax Identification Number (EIN or TIN): \_\_\_\_\_
Contact Name: \_\_\_\_\_
Contact Phone Number: \_\_\_\_\_

D e p n i t ' H l p c p e k n l k p u n k w l k q p ' k p h t o c v k q p "

Bank / Financial Institution Name: \_\_\_\_\_
Address: \_\_\_\_\_
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
ACH/EFT Contact Name: \_\_\_\_\_
ACH/EFT Contact Phone Number: \_\_\_\_\_
Routing Transit Number: \_\_\_\_\_
Account Number: \_\_\_\_\_
Type of Account (circle one): Checking Savings

C w j q t k c v k q p "

We, the Provider, certify the above checking or savings account is under our direct control. Therefore, we authorize Missouri Care, Incorporated to initiate credit entries (and/or adjustments for any credit entries made in error) directly into the Bank / Financial Institution account number listed above. We authorize the Bank / Financial Institution to post the credit and/or debit to the same account.

We understand that if our account is closed, we will not receive payment until our bank returns the funds to Missouri Care, Incorporated. This authorization remains in effect until we submit an updated EFT Authorization Form requesting termination and until such time that Missouri Care, Incorporated has had a reasonable opportunity to act on such request. If our depository information changes, we agree to submit an updated EFT authorization form.

U i p c w t g "

Authorized Provider Representative: \_\_\_\_\_ (PRINT NAME)
Authorized Provider Representative: \_\_\_\_\_ (SIGNATURE)
Job Title: \_\_\_\_\_ Date: \_\_\_\_\_

I g p g t c n l k p h t o c v k q p "

, "Attach a VOIDED check for verification of your account number. , "

Completed forms and attachments should be returned by mail or faxed to the following:
Missouri Care Incorporated Fax: 866-946-1105
Attn: Provider Relations or
2404 Forum Boulevard
Columbia, MO 65203

Q H H E G ' W U G ' Q P N [

Date Form Received by Plan: \_\_\_\_\_ Bank Information Verified (initial): \_\_\_\_\_
Provider ID Number: \_\_\_\_\_ Date Provider Set-up: \_\_\_\_\_