**STATE OF ARIZONA – ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM**

**Electronic Funds Transfer (EFT) Authorization Agreement**

Attn: AHCCCS Finance- MD 5400, P.O. Box 25520, Phoenix, AZ 85002

Fax Number: 602-258-5943

* REQUIRED FIELD + REQUIRED FIELD IF SECTION IS APPLICABLE

**SECTION 1**

**PROVIDER IDENTIFIER INFORMATION**

Provider Name * _____ Doing Business As Name (DBA) _____

Provider Address _____ _____ _____ _____

Street * City * State/Province * Zip Code/Postal Code *

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) * _____

National Provider Identifier (NPI)* _____ Trading Partner ID(AHCCCS Provider Number)* _____

**SECTION 2**

**PROVIDER CONTACT INFORMATION**

_____ _____

Provider Contact Name * Title

_____

Telephone Number & Extension*

_____ _____

Email Address * Fax Number

**SECTION 3**

**PROVIDER AGENT INFORMATION - IF APPLICABLE**

Provider Agent Name + _____

_____ _____ _____ _____

Agent Address Street + City + State/Province + Zip Code/Postal Code +

_____ _____

Provider Agent Contact Name + Title

_____

Telephone Number & Extension +

_____ _____

Email Address + Fax Number

**SECTION 4**

**FINANCIAL INSTITUTION INFORMATION**

Financial Institution Name * _____

_____ _____ _____ _____

Financial Institution Address Street * City * State/Province * Zip Code/Postal Code *

_____

Financial Institution Telephone Number & Extension

Financial Institution Routing Number * _____

Type of Account at Financial Institution * Checking _____ Savings _____

Provider's Account Number with Financial Institution * _____

Account Number Linkage to Provider Identifier *

Provider's Federal Tax Identification Number OR National Provider Identifier Number

_____ _____

**SECTION 5**

**SUBMISSION INFORMATION**

Reason for Submission * New Enrollment _____ Change Enrollment _____ Cancel Enrollment _____

Include with Enrollment Submission * Voided Check - A voided check is attached to provide confirmation of identification/account numbers

OR

_____ Bank Letter - A letter on bank letterhead that formally certifies the account owners routing and account numbers

**SECTION 6**

**AUTHORIZATION**

Pursuant to A.R.S. Sec. 35-185, I authorize theArizona Department of Administration (ADOA, General Accounting Office (GAO) and the Arizona Health Care Cost Containment System (AHCCCSA) to process payments owed to me via Automated Clearing House (ACH) deposits. The State of Arizona and AHCCCSA shall deposit the ACH payments in the financial institution and account designated above.

*** I recognize that if I fail to provide complete and accurate information** on this authorization form, the processing of the form may be delayed or made impossible, or my electronic payments may be erroneously made.

I authorize the State of Arizona and AHCCCSA to withdraw from the designated account all amounts deposited electronically in error in accordance with NACHA rules and timelines. If the designated account is closed or has an insufficient balance to allow withdrawal, then I authorize the State of Arizona and AHCCCSA to withhold any payment owed to me by the State of Arizona and AHCCCSA until the erroneous deposited amounts are repaid. If I decide to change or revoke this authorization, I recognize that I must forward such notice to AHCCCSA, Attn: Finance Dept., Mail Drop 5400, P.O. Box 25520, Phoenix, AZ 85002. The change or revocation is effective on the day that ADOA/GAO and AHCCCSA process the request.

I certify that I have read and agree to comply with the State of Arizona and AHCCCSA' s rules governing payments and electronic transfers as they exist on the date of my signature on this form or as subsequently adopted, amended, or repealed. I consent to, and agree to, comply with these rules even if they conflict with this authorization form.

I authorize the State of Arizona and AHCCCSA to stop making electronic transfers to my account without advance notice.

I certify that I am authorized to contract for the entity receiving deposits, pursuant to this agreement, and that all information provided is accurate.

**The financial institution can process CCD+ payments/transactions along with addendum information. * Yes _____ No_____**

_____ _____ _____

Authorized Signature * Print Name of Authorized Signer * Title

Submission Date * _____ Requested EFT Start/Change/Cancel Date * _____