ELECTRONIC FUNDS TRANSFER (EFT) ENROLLMENT INSTRUCTIONS

Providers who receive payment of claims via Electronic Funds Transfer from **STATE OF ALASKA** Department of Health and Social Services Medicaid Program must agree to the following terms and conditions:

1. **Legal Compliance**. Provider shall abide by all Federal and State laws governing the **STATE OF ALASKA** Department of Health and Social Services Medicaid Program.
2. **EFT Information**. Provider will complete EFT information on the EFT application and submit a bank letter or voided check from the account to which funds will be transferred. Note in this form, Other Identifier is for the Medicaid ID.
3. **Attestation and Authorization -** I hereby authorize and request the Alaska Department of Health and Social Services (DHSS) to initiate credit entries to my account as described above and corresponding to the account information supplied and the depository (bank) named above is authorized to credit such account. I agree that evidence of credit to the proper account by the Provider's bank pursuant to an EFT is sufficient to show acceptance of Alaska Medical Assistance payments. I certify by such acceptance that I presented the claims for the services shown on the Remittance Advice issued by the DHSS and that the services were rendered by me or under my supervision. I understand that payment will be from Federal and State funds and that any falsification or concealment of a material fact may be prosecuted under Federal and State laws.
   If a reversal action is required, DHSS will notify the receiver of the error and give the reason for reversal. If any action taken by me without adequate notification to DHSS results in non-acceptance of the transfer by the designated financial institution, I understand that DHSS assumes no responsibility for processing supplemental payments until the funds are returned to DHSS by the financial institution.
   The authority will continue until DHSS has had a reasonable opportunity to act upon my written request to terminate EFT service or until DHSS determines that the required qualifications for enrollment are no longer being maintained.
4. **Notice of Changes**. Provider will notify the Department in writing at least ten (10) days in advance of any changes in Payee, Payee's name or address, or bank account name or number (supported by a bank letter or voided check on the new account).
5. **Alternate Payment Methods**. For good cause (including but not limited to recovering overpayments from subsequent requests for claims payments), the Department may substitute payment by check for EFT until the cause requiring the substitution has been satisfied as determined by the Department. Payment by check will be made to the billing address for payments on record with the Department.
6. **Expiration or Termination of EFT**. Violation of these terms may cause termination of EFT and/or the AK Medicaid Program Participation Agreement by the Department. Expiration or termination of the AK Medicaid Program Provider Participation Agreement for any reason will terminate EFT automatically. The Department will give written notice of termination to the Provider.
7. **CCD+ Format.** Provider will contact its financial institution/bank to arrange for the delivery of the information from the CCD+ EFT that is necessary for successful re-association of the EFT payment with the ERA remittance advice. The information that the bank must return is as follows:

CORE-required Minimum CCD+ Re-association Data Elements		Corresponding v5010 X12 835 Data Elements	
CCD+ Record #	**Field #**	**Field Name**	**Data Element Segment Position, Number & Name**
5	9	Effective Entry Date	BPR16-373 Date (EFT Effective Date)
6	6	Amount	BPR02-782 Monetary Amount (Total Actual Provider Payment Amount)
7	3	Payment Related	TRN Re-association Trace Number Segment

TRN segment consists of Check or EFT trace number/Payer Identifier/optional supplemental code. These pieces of information will match what is received in the ERA (835) transaction for easy re-association.

Providers must contact their financial institution to arrange for the delivery of the minimum required fields for re-association. The banks will not automatically supply this detail and it is required that the provider work out how this information will be obtained (email, e-statement, electronically, etc.).

10. **Late/Missing EFT.** In case of a late or missing EFT, the Provider will contact the Provider Relations call center at **1-907-644-6800**. Late or missing is defined as a maximum elapsed time of four (4) business days following the receipt of ERA.
11. **Change/Cancel Enrollment.** If any changes are required to EFT enrollment information, the Provider will contact the Provider Relations call center at **1-907-644-6800**. In State Toll Free 800-770-5650
12. **TIN/FEIN.** Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) field in the EFT section is equivalent to Social Security Number (SSN) for Individual Providers and Federal Employer Identification # (FEIN) for Group Providers.
13. **Bulking** While this form asks for the Account number linkage Alaska State Medicaid does not bulk at NPI or TIN level. Remittances are bulked by Medicaid ID.

Contact Information:
Conduent State Healthcare, LLC
Finance Department
P.O. Box 240807
Anchorage, Alaska 99524-0808

Telephone number: (907) 644-6800
In-state toll-free number: (800) 770-5650