Connecticut Medical Assistance Program
Authorization for Electronic Funds Transfer (EFT)

The Department of Social Services (DSS) requires providers to participate in electronic funds transfer (EFT), with the exception of providers located out-of-state providing approved services to Connecticut Medical Assistance Program clients. However, if it is a hardship to do so and you elect not to participate in the EFT program, then you may be subject to a per paper check processing fee. Please note that although there is no service charge at this time, this is an option the Department may pursue in the future. EFT is a more efficient and cost effective means of reimbursement for Connecticut Medical Assistance Program services. In order to enroll in EFT, providers must complete the form on the following page.

The EFT process will take approximately four to six weeks to be completed. Providers will have an initial EFT status of pre-notification, at which time EDS will send a test EFT transaction to the Bank of America. During this time, providers will receive a paper check. Providers will remain in this status until a successful pre-notification transaction has been confirmed. Once a successful transaction is made, providers will begin to receive their funds via EFT beginning with the next claims processing cycle. The first time a paper check is not received, providers should confirm with their bank that an EFT has been made.

Providers must inform EDS of any changes to their bank account (i.e. account number, ABA number) by submitting an updated "Authorization for Electronic Funds Transfer" form to the EDS Provider Enrollment Unit at P.O. Box 5007, Hartford, CT 06104. Updates to this data may also be made at www.ctdssmap.com. This action will place the provider in a pre-notification status and the provider will once again receive a paper check until a successful pre-notification transaction has been confirmed. Failure to inform EDS of a change to your bank account information may result in a delay in receiving your paper check.

The ASC X12N 835, Electronic Remittance Advice, will include EFT information. The financial information segment (BPR) will include the following fields:

BPR05 - Payment Code = "CCP"	BPR10 - DSS EIN Number
BPR06 – ID Qualifier Number = "01"	BPR12 - Depository Financial Institution Identification Number Qualifier = "01"
BPR07 - Bank ABA Routing Number	BPR13 - Receiver or Provider Bank ID Number
BPR08 - Account Number Qualifier = "DA"	BPR14 - Type of account
BPR09 - DSS Bank Account Number	BPR15 - Receiver or Provider Account Number

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Complete the section below and attach a copy of a voided check for a checking account, a deposit slip for a savings account or documentation from your banking institution confirming the bank account and routing number that will be utilized for the EFT deposit. The bank transit routing number, also known as the American Banking Association (ABA) routing number can be obtained from your bank.

An AVRS ID is issued when a provider successfully enrolls into the Connecticut Medical Assistance Program. If you are a newly enrolling provider, please leave this field blank. If you are a re-enrolling provider, your AVRS ID can be found on your initial Welcome Letter that you received at the time of enrollment or on the Banner Page of your Remittance Advice.

Type of Authorization **NEW _____** **CHANGE _____**

AVRS ID	PROVIDER NAME
BANK NAME	**BANK TRANSIT ROUTING/ABA NUMBER**
ACCOUNT NUMBER	**TYPE OF ACCOUNT**
	CHECKING _____ SAVINGS_____

I agree to keep, and disclose upon request to authorized agencies, records that disclose fully the extent of payments claimed from the services rendered to clients of the Connecticut Medical Assistance Program. I accept as payment in full the amount paid by the Connecticut Medical Assistance Program for claims submitted with the exception of authorized cost sharing by recipients. I understand payment of this claim is from state and federal funds and that any false claims, statements, documents or concealment of a material fact may be prosecuted under state or federal law. This is to certify that the information submitted to obtain this payment is true, accurate and complete.

I authorize the electronic transfer of Connecticut Medical Assistance Program payments made to the above provider number(s). I understand that I am responsible for the validity of the above information.

_____ _____

Contact Name Address

_____

Email Address

_____ _____

Signature Date

Return this form to:
EDS
P.O. Box 5007
Hartford, CT 06104

Please Note: Connecticut Medical Assistance Program providers who are currently enrolled in EFT are not required to complete this form. Providers must, however, inform EDS of any changes to this information by submitting an updated form or by updating this information at www.ctdssmap.com.