



Iowa Department of Human Services

Consumer Directed Attendant Care Providers – AFSCME Members Authorization Form for Payment to Business Agent

This form authorizes my Medicaid payments to be sent to AFSCME's bank account for dues deductions and other deductions AFSCME is authorized to make. AFSCME will then make the payments to the CDAC provider.

Effective Date:		
Specify Reason: AFSCME Deductions		
Provider Name: (please print)		Telephone:
Provider Address:		
City:	State:	Zip Code:
Social Security Number/Taxpayer ID:		Provider ID Number/NPI:

I hereby authorize the Iowa Medicaid Program to send my Medicaid payments to American Federation of State, County, and Municipal Employees Iowa Council 61 (AFSCME), which will be administered by BMGI on behalf of the AFSCME. I understand that AFSCME union dues certified by AFSCME Council 61 Local 1100 and other deductions I authorize AFSCME to make will be deducted by BMGI from my Iowa Medicaid payments and that any remaining funds will then be forwarded to me by BMGI.

Payment to the above account by the Iowa Medicaid Program shall be considered payment to me. I understand that any questions I may have relating to deductions from my payment for union dues or other deductions I authorize AFSCME to make shall be directed to AFSCME at 515-246-1517 or 1-800-372-6054 and that I will have no claims, demands or causes of action against the Iowa Medicaid Program that relate to or arise out of such deductions. Any questions regarding claims adjudication shall be directed to Iowa Medicaid Program Provider Services at 1-800-338-7909 (outside the Des Moines area) or 515-256-4609 (Des Moines local calls).

This authorization shall remain in effect until such time as I revoke it by giving 60 days written notice to Iowa Medicaid Enterprise. The written notice must be signed and dated by me and sent to Iowa Medicaid Enterprise and AFSCME.

I understand that payment is made from state and federal funds and that any falsification or concealment of a material fact may be prosecuted under state and federal laws. I understand that my signature certifies acceptance of the provider certification on the claim form and/or Provider Agreement. I also certify that I am legally authorized to make this certification, and that I may be prosecuted under applicable state or federal laws for any false statements or documents submitted.

Authorized By Signature of Authorizing Person:	Date:
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Consumer Directed Attendant Care Providers – AFSCME members
BMGI/AFSCME Form

**This form directs BMGI/AFSCME on how I want to receive my Medicaid payments after dues and other deductions are made.

<input type="checkbox"/> New EFT Enrollment	<input type="checkbox"/> EFT Change	Effective Date:	
		Specify Reason:	
Provider Name: (please print)		Telephone: ()	
Provider Address:			
City:		State:	Zip Code:
Taxpayer ID:		Provider ID Number/NPI:	
Payments to me should be made by (select one): <input type="checkbox"/> Electronic Funds Transfer to my bank account (fill in bank account information in the box below.) <input type="checkbox"/> Check mailed to the address listed above. <input type="checkbox"/> Check mailed to the address listed below (fill in the address where you want the check to be mailed):			

Electronic Funds Transfer Bank Information (Account where I want my Payments to be sent)	
Financial Institution:	
ABA Routing Number:	
Account Number:	
Type of Account: <input type="checkbox"/> Checking	<input type="checkbox"/> Savings

Authorized By: Signature of Authorizing Person:	Date:
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