Iowa Department of Human Services

Electronic Fund Transfer (EFT) Authorization Form Instructions

The form is available electronically at www.tfaforms.com/284316. If you have questions regarding Electronic Fund Transfer (EFT) or are in need of assistance in filling out the EFT form, or to check the status of your EFT form submission, please contact Provider Enrollment at 1-800-338-7909 (option 2) or locally (in the Des Moines area) at 515-256-4609 (option 2). Provider Enrollment representatives are available Monday-Friday 7:30 AM-4:30 PM.

FIELD NO.	FIELD NAME/DESCRIPTION	REQUIREMENTS	INSTRUCTIONS
ORGANIZATION INFORMATION			
1	PROVIDER NAME	**REQUIRED**	Enter complete legal name of institution, corporate entity, practice or individual provider.
2	STREET	**REQUIRED**	Enter the number or street name where the provider or organization can be found.
3	CITY	**REQUIRED**	Enter the city associated with the provider address field.
4	STATE	**REQUIRED**	Enter the state associated with the provider address field.
5	ZIP CODE/POSTAL CODE	**REQUIRED**	Enter the complete zip code associated with the provider address field.
6	PROVIDER FEDERAL TAX IDENTIFICATION NUMBER (TIN) OR EMPLOYER IDENTIFICATION NUMBER (EIN)	**REQUIRED**	Enter a Federal Tax Identification Number or Employer Identification Number
7	NATIONAL PROVIDER IDENTIFIER (NPI)	**REQUIRED**	Enter the 10 character National Provider Identifier as confirmed with the Iowa Medicaid Enterprise (IME).

CONTACT INFORMATION OF PERSON COMPLETING THIS FORM			
8	PROVIDER CONTACT NAME	**REQUIRED**	The provider or the authorized representative completing this document must provide both first and last name for communication purposes.
9	TELEPHONE NUMBER	**REQUIRED**	Enter the telephone number (including) area code for the person completing this form.
10	TELEPHONE NUMBER EXTENSION	**SITUATIONAL**	No entry required. Enter the extension associated with the phone number field.
11	EMAIL ADDRESS	**REQUIRED**	Enter the email address for the person completing this form.

DIRECT DEPOSIT INFORMATION			
12	FINANCIAL INSTITUTION NAME	**REQUIRED**	Enter the official name of the financial institution.
13	STREET	**REQUIRED**	Enter the number and street name where the financial institution can be found
14	CITY	**REQUIRED**	Enter the city associated with the financial institution address field.
15	STATE	**REQUIRED**	Enter the state associated with the financial institution address field.
16	ZIP CODE/POSTAL CODE	**REQUIRED**	Enter the complete zip code financial institution with the provider address field.
17	FINANCIAL INSTITUTION ROUTING NUMBER	**REQUIRED**	Enter a 9-digit identifier of the financial institution where the provider maintains an account to which payments are deposited.
18	TYPE OF ACCOUNT AT FINANCIAL INSTITUTION	**REQUIRED**	Select the type of account the provider maintains with the financial institution.
19	PROVIDER'S ACCOUNT NUMBER WITH FINANCIAL INSTITUTION	**REQUIRED**	Enter the provider's account number with financial institution.

20	ACCOUNT NUMBER LINKAGE TO PROVIDER IDENTIFIER	**REQUIRED**	Select the preference for grouping claim payments. Must match preference for V5010 X12 835 remittance advice.
21	REASON FOR SUBMISSION	**REQUIRED**	Select the type of enrollment
22	COPY OF A VOIDED CHECK OR BANK VERIFICATION LETTER	**REQUIRED**	Attach a copy of a voided check or Bank Verification Letter. It must contain the name and address of financial institution with the matching account information contained on this form.
23	AUTHORIZED SIGNATURE	**REQUIRED**	The provider or authorized representative must electronically sign their name.

- If you are enrolling in Electronic Fund Transfer (EFT), we recommend contacting your Financial Institution to arrange for the delivery of the Committee on Operating Rules for Information Exchange (CORE) required minimum Corporate Credit or Debit Entity Plus Addenda Record (CCD+ Data) elements necessary for successful reassociation of the EFT files to their corresponding ERA files. For more information, please see this link* from the Council for Affordable Quality Healthcare (CAQH) website.

* http://www.caqh.org/Host/CORE/EFT-ERA/Sample_Provider_EFT_Reassociation_Data_Request_Letter.pdf