



Iowa Department of Human Services  
**Electronic Fund Transfer (EFT)  
Authorization Form**

This form is intended to be used by providers who would like to receive claim payments via an Electronic Funds Transfer (EFT). This form should be completed upon initial enrollment, if you change your financial institution, or if there is a change in your financial account status.

- [Electronic version of this EFT Authorization Form](#)
- [Electronic Funds Transfer \(EFT\) Authorization Form \(470-4202\) Instructions](#)

**Provider Information**

<b>Provider Name</b>		
<b>Street</b>		
<b>City</b>	<b>State/Province</b>	<b>Zip Code/Postal Code</b>

<b>Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)</b>
<b>National Provider Identifier (NPI)</b>

**Provider Contact Information** (*Contact information of the person completing this form*)

<b>Provider Contact Name</b>	
<b>Telephone Number</b>	<b>Telephone Number Extension</b>
<b>Email Address</b>	

**Financial Institution Information**

<b>Financial Institution Name</b>		
<b>Street</b>		
<b>City</b>	<b>State/Province</b>	<b>Zip Code/Postal Code</b>
<b>Financial Institution Routing Number</b>	<b>Type of Account at Financial Institution</b>	
	<b>Checking</b>	<b>Savings</b>
<b>Provider's Account Number with the Financial Institution</b>		
<b>Account Number Linkages to Provider Identifier</b>		
<b>Provider Tax Identification Number (TIN)</b>		
<b>National Provider Identifier (NPI)</b>		

**Reason for Submission\***

New Enrollment

Enrollment Change

Cancel Enrollment

*\* This enrollment submission must include a "voided check" or a bank letter that contains the name and address of the financial institution with the matching account information contained on this form.*

**Authorized Signature and Date** (print name and date then read and check the statement below)

By signing this document I authorize (check the box) the Iowa Medicaid Program to apply my Medicaid payments to the account specified above. 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 electronic 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.

**You may fill out, print, and mail or fax the completed form to:**

Iowa Medicaid Enterprise  
 Provider Services Unit  
 PO Box 36450  
 Des Moines, IA 50315  
 Fax to (515) 725-1155  
 Email: [IMEproviderservices@dhs.state.ia.us](mailto:IMEproviderservices@dhs.state.ia.us)