WASHINGTON STATE
HEALTH CARE AUTHORITY
MEDICAID PURCHASING ADMINISTRATION

Authorization Agreement for Electronic Funds Transfer (EFT)

PROVIDER NAME

MEDICAID PROVIDER NUMBER (VENDOR ID)

STREET ADDRESS

IRS / EIN NUMBER

CITY

CONTACT PERSON TITLE

STATE ZIP CODE + 4

TELEPHONE NUMBER (WITH AREA CODE)

I hereby authorize and request the Washington State Department of Social and Health Services (DSHS) to initiate credit entries to my ☐ checking ☐ savings account (select one) indicated below, and the depository named below is authorized to credit such account. If a reversal action is required, DSHS will notify the receiver of the error and give the reason for reversal. If any action taken by me, without adequate notification to DSHS, results in non-acceptance of the transfer by the designated financial institution, I understand that DSHS assumes no responsibility for processing supplemental payments until the funds are returned to DSHS by the financial institution.

DEPOSITORY (BANK) NAME

* TRANSIT ROUTING NUMBER

** ACCOUNT NUMBER

* The transit routing number is the 9-digit target Bank Identification number assigned by the American Banking Association.

** The account number is the provider's bank account number to which funds will be transferred.

This authority will continue until DSHS has had a reasonable opportunity to act upon my written request to terminate EFT service or until DSHS determines that the required qualifications for enrollment are no longer being maintained.

AUTHORIZATION (PRINT)

TITLE (PRINT)

AUTHORIZATION SIGNATURE ON ACCOUNT

DATE

PLEASE MAIL OR FAX FORM TO: HCA – MEDICAID PURCHASING ADMINISTRATION
PO BOX 45562
OLYMPIA WA 98504-5562
FAX (360) 725-2144