Iowa Department of Human Services

Electronic Funds Transfer (EFT) Authorization Form

Iowa Medicaid Program

Please return this completed form to: Provider Services Unit, Iowa Medicaid Enterprise P.O. Box 36450 Des Moines, IA 50315 or fax to (515) 725-1155

☐ New EFT Enrollment	☐ EFT Change
Provider Name:	
Taxpayer ID:	National Provider Identifier:

Required: Submit a copy of a voided check or Bank verification letter

Direct Deposit Information

Financial Institution Name:		
ABA Routing Number:		
Financial Institution Account Number:		
Type of Account:	☐ Checking	☐ Savings

I hereby authorize 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 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:

Name of Authorizing Person (Please Print):	
Title of Authorizing Person:	
Telephone Number:	
Signature of Authorizing Person:	Date: