ELECTRONIC FUNDS TRANSFER ATTESTATION

Request Date _____ WEB Request Trans # _____
MMIS Provider ID # _____ NPI _____
Provider/Organization Name_____

If submitting the form for a practitioner, the practitioner must sign. If submitting this form for a group, business or institution, the authorized representative must sign below. Only original signatures are accepted. Stamped signatures or copies will be returned.

The eMedNY Fiscal Agent contractor for the New York State Department of Health will have the right to recover any amount that has been credited to your account incorrectly.

Signature of Provider/Authorized Representative *Date Signed*

Print Name of Provider/Authorized Representative *Title*

Attach an original, voided check here

Please attach an original defaced/voided check or an original letter from your banking institution to this form.
Sign the form and follow the mailing instructions.
Questions should be directed to eMedNY Call Center at 1-800-343-9000.

FOR EMEDNY USE ONLY – DO NOT WRITE

Date Received:_____

Pick Up Indicator: No: ☐ Yes: ☐ Facility Location:_____

Processed by:_____ Date:_____

Authorized by:_____ Date:_____

Effective Start Date:_____ Cycle #:_____

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Attach one of the following banking documents to the Electronic Funds Transfer Attestation Form:

a. **For Checking Accounts:** An **original** blank check from the checking account to which the funds are to be transferred. The word "VOID" must be written across the face of the check. The check must contain the name and address of the provider or provider organization.

b. **For deposit-only checking accounts** (and you do not have checks) **or to have the EFT deposited in a savings account:** Submit an **original** letter from a bank officer. The letter must be on bank letterhead, signed by a bank officer, notarized by a notary public, and include the following information: the bank's name and address, routing number, the type of account, account number, the account owner's name, owner's address and tax ID.

Mailing Instructions:

Non-Enrolled providers: Include this form with your enrollment package and mail to the address designated in the enrollment instructions.

Enrolled Medicaid providers: Please sign and mail this form to:

EFT Processing
eMedNY Provider Services
P.O. Box 4616
Rensselaer, NY 12144-4616

Questions about form completion should be directed to the eMedNY Call Center at 1-800-343-9000.

What to Expect when you are an enrolled Medicaid Provider:

Please allow a minimum time of 6-8 weeks for your request to be processed. During the process period a test transaction for one cent will be transferred to your account.

For providers who have claims paid within a particular payment cycle, Medicaid funds are normally scheduled to be transferred on Wednesday afternoons. Due to normal banking procedures, the funds may not become available in the provider's chosen account for up to 48 hours from the initial transfer. Please contact your banking institution with questions about the availability of funds.

EFT does not waive the two week lag for release of Medicaid payments.

Instructions to Cancel EFT Transactions

To cancel EFT transactions, submit a written notice, including the provider number(s), applicable MMIS and/or NPIs, to the address above. Please verify your Pay-to Address on file is correct by calling the eMedNY Call Center at 1-800-343-9000. If the address needs to be updated, a Change of Address Form is available at www.emedny.org.

Please allow 5-6 weeks to transition to a **paper check**.

To avoid a delay in payment please DO NOT close your account until all outstanding payments have been received.