EFT	ELECTRONIC FUND TRANSFER AUTHORIZATION	DEPARTMENT OF HEALTH CARE SERVICES – MEDI-CAL: This authorization remains in full force and effect until the California Medicaid Program/Title XIX receives written notification from the provider of its termination, or until the California Medicaid Program/Title XIX or appointing authority deems it necessary to terminate the agreement.

DIRECTIONS: An original pre-imprinted voided check for checking accounts, or an original bank letter for savings accounts, must be submitted with this form. The provider name, routing number and account number on either of those documents must match what is entered on this form. Photocopied documents will not be accepted. Use blue ink for signatures, including notary.

SECTION A

PLEASE PRINT OR TYPE

1. NAME OF PROVIDER (must match name on bank account and name registered with Medi-Cal)			2. NPI OR LEGACY NUMBER (one EFT form per number)
3. NAME OF MAIN CONTACT PERSON			4. TELEPHONE NUMBER
5. PROVIDER ADDRESS	CITY	STATE	ZIP
6. LAST 4 DIGITS OF PROVIDER SOCIAL SECURITY NUMBER OR COMPLETE FEDERAL TAX ID NUMBER (must match number registered with Medi-Cal)			

SECTION B

1. BANK ROUTING NUMBER	2. BANK ACCOUNT NUMBER (include leading zeros)	3. TYPE OF ACCT ☐ CHECKING ☐ SAVINGS
4. BANK NAME		
5. BANK ADDRESS	CITY STATE ZIP	

SECTION C (Check the appropriate box)

☐ I hereby authorize the California Medicaid Program/Title XIX to initiate credit entries to my bank account as indicated above, and the depository named above to credit the same to such account. For changes to existing accounts, do not close an existing account until the first payment has been deposited into the new account**.**

☐ I hereby CANCEL my EFT authorization.

I understand that by signing this form, payments issued will be from Federal and State funds, and that any falsification or concealment of a material fact may be prosecuted under Federal and State laws.

Provider Signature (BLUE INK ONLY. Must be owner or corporate officer.) Date

FORM MUST BE NOTARIZED

MAIL THIS FORM TO:

Xerox State Healthcare, LLC
Attn: EFT Unit
PO Box 13029
Sacramento, CA 95813-4029

EXPRESS MAIL ONLY
Xerox State Healthcare, LLC
Attn: EFT Unit
820 Stillwater Road
West Sacramento, CA 95605

Privacy Statement (Civil Code Section 1798 et seq.): The information requested on this form is required by the Department of Health Care Services for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your request being delayed or not processed.