



## Authorization Agreement for State Medicaid Payments

### **Applicants**

To apply for EFT of your Medicaid payments, you must complete the accompanying form (OBM 5678) and return it to the address indicated on the form. Do not submit the form until after your provider number has been assigned. Do not mail the form to CareStar or ODJFS-if you do, it will be returned to you. You must submit the form to the address on the form (listed below).

### **Current Providers**

To apply for, change or delete EFT of your Medicaid payments, you must complete the accompanying form (OBM 5678) and return it to the address indicated on the form. Do not mail the form to CareStar or ODJFS. Do not mail the form to CareStar or ODJFS-if you do, it will be returned to you. You must submit the form to the address on the form (listed below).

Read the form carefully for complete instructions. You may access an interactive version of the form at the ODJFS website at:

<http://jfs.ohio.gov/OHP/bpo/pnms/provenroll.stm>

### **The completed EFT request form must be returned to:**

Ohio Shared Services  
Attn: Vendor Maintenance  
4310 E. Fifth Avenue  
Columbus, OH 43219

(Do not mail any other type of correspondence to the above address.)

For questions about the EFT process, contact Shared Services at 877-644-6771 or 614-338-4781. Do not call this number for general questions about your provider status.

You must notify Shared Services and ODJFS of any change to your banking information. In addition, you are required to notify ODJFS Provider Enrollment of any change to your name or address within thirty days of the change. To contact ODJFS Provider Enrollment, call 800-686-1516.



# AUTHORIZATION AGREEMENT FOR STATE MEDICAID PAYMENTS

- To apply for EFT, change, or delete please **TYPE or PRINT** the information requested in SECTION 1 - 3. The information provided must be **legible**. SECTION 4 must be signed & dated. **Please attach** a copy of a Voided Check (if a savings account, a letter from your bank stating your account & routing number). **Please return original form to: Ohio Shared Services, ATTN: Vendor Maintenance, 4310 E. Fifth Avenue, Columbus, OH 43219.**
- Do not submit until your provider number has been assigned.
- Any account changes must be reported to Ohio Shared Services thirty (30) days prior to actual change. If changing banking information, please complete SECTION 3 with your new financial information.
- It is the **provider's responsibility** to keep the Ohio Department of Job & Family Services **AND** Ohio Shared Services informed of any bank changes in order to receive important information about benefits and to remain qualified for payments.
- Call Provider Enrollment at (800) 686-1516 for information to a change of name or address.

**THE PROVIDER NAME, TAX ID NUMBER, AND PROVIDER NUMBER MUST MATCH THE INFORMATION ON FILE WITH MEDICAID OR YOUR FORM WILL BE RETURNED. IF IN DOUBT, VERIFY INFORMATION WITH PROVIDER ENROLLMENT AT (800) 686-1516.**

## SECTION 1

TYPE OF TRANSACTION:		<input type="checkbox"/> ADD	<input type="checkbox"/> CHANGE	<input type="checkbox"/> DELETE
PROVIDER NAME: <input style="width: 100%;" type="text"/>				
PROVIDER MAILING ADDRESS: <input style="width: 100%;" type="text"/>				
CITY STATE & ZIP: <input style="width: 100%;" type="text"/>				
PHONE: <input style="width: 50%;" type="text"/>		EMAIL: <input style="width: 100%;" type="text"/>		
FEDERAL TAX ID OR SOCIAL SECURITY NUMBER: <input style="width: 50%;" type="text"/>		<b>ODJFS MEDICAID PROVIDER NUMBER: (MUST BE PROVIDED)</b> <input style="width: 50%;" type="text"/>		

## SECTION 2 – CURRENT FINANCIAL INFORMATION

FINANCIAL INSTITUTION NAME: <input style="width: 60%;" type="text"/>	PHONE: <input style="width: 30%;" type="text"/>
ADDRESS: <input style="width: 100%;" type="text"/>	
TYPE OF ACCOUNT:	
<input type="checkbox"/> SAVINGS	<input type="checkbox"/> CHECKING
TRANSIT ROUTING/ABA NUMBER: <input style="width: 100%;" type="text"/>	
PROVIDER'S ACCOUNT NUMBER AT ABOVE INSTITUTION: <input style="width: 100%;" type="text"/>	

## SECTION 3 – NEW FINANCIAL INFORMATION

FINANCIAL INSTITUTION NAME: <input style="width: 60%;" type="text"/>
ADDRESS: <input style="width: 100%;" type="text"/>
TYPE OF ACCOUNT:
<input type="checkbox"/> SAVINGS <input type="checkbox"/> CHECKING
TRANSIT ROUTING/ABA NUMBER: <input style="width: 100%;" type="text"/>
PROVIDER'S ACCOUNT NUMBER AT ABOVE INSTITUTION: <input style="width: 100%;" type="text"/>



## AUTHORIZATION AGREEMENT FOR STATE MEDICAID PAYMENTS

### SECTION 4

- Whereby authorize Ohio Office of Budget and Management to initiate credit entries to our account in the financial institution identified above and also debit entries, if necessary, for any credit entries that are determined to be in error. We additionally authorize the financial institution to credit or debit the same to our account.
- This authority is to remain in effect until revoked by us in writing to Ohio Shared Services.

PROVIDER SIGNATURE:

DATE:

DO NOT WRITE BELOW THIS LINE. OSS USE ONLY

DATE RECEIVED	DATE ENTERED	INITIALS

#### SUBMIT FORM TO:

**Mail:** Ohio Shared Services  
ATTN: Vendor Maintenance  
4310 E. Fifth Ave. Columbus, OH 43219

#### QUESTIONS? PLEASE CONTACT:

**Phone:** 1 (877) OHIO - SS1 (1-877-644-6771)  
1 (614) 338-4781  
**E-mail:** [vendor@ohio.gov](mailto:vendor@ohio.gov)