Connecticut Department of Social Services
Medical Assistance Program
Provider Bulletin

PB 2006-42 **June 2006**

TO: **All Providers**

SUBJECT: **Electronic Funds Transfer (EFT) Mandate for Reimbursement of Connecticut Medical Assistance Program Services**

Beginning **July 2006,** the Department of Social Services (DSS) will **mandate** enrollment in EFT for all providers at the time of their scheduled reenrollment. EFT offers many benefits and enrollment is simple! A copy of the EFT form will be included in your reenrollment packet. The EFT form should be returned to EDS with the reenrollment application as indicated in the reenrollment instructions.

Providers who are currently enrolled in EFT do not need to take any action. Providers who are not currently enrolled in EFT may choose to do so prior to their reenrollment date.

In order to enroll in EFT, providers must submit an "Authorization for Electronic Funds Transfer" form with a copy of a voided check for a checking account, a deposit slip for a savings account or documentation from your banking institution confirming the bank account and routing number that will be utilized for the EFT deposit. A copy of the form is attached to this bulletin for those providers who wish to enroll at this time. The EFT form can also be downloaded from the Connecticut Medical Assistance Program website www.ctmedicalprogram.com. From the home page, click on "Publications" → "Forms" → "Authorization for EFT". The EFT form must be returned to EDS at the address indicated on the form.

The EFT process will take approximately four to six weeks to be completed. Providers will have an initial EFT status of pre-notification, at which time EDS will send a test EFT transaction to the Bank of America. During this time, providers will continue to receive a paper check. Providers will remain in this status until a successful pre-notification transaction has been confirmed. Once a successful transaction is made, providers will begin to receive their funds via EFT beginning with the next claims processing cycle. The first time a paper check is not received, providers should confirm with their bank that an EFT has been made.

Providers must inform EDS of any changes to their bank account (i.e. account number, ABA number) by submitting an updated "Authorization for Electronic Funds Transfer" form to the EDS Provider Enrollment Unit at P.O. Box 5007, Hartford, CT 06104. This action will place the provider in a pre-notification status and the provider will once again receive a paper check until a successful pre-notification transaction has been confirmed. Failure to inform EDS of a change to your bank account information may result in a delay in receiving your paper check.

The ASC X12N 835, Electronic Remittance Advice, will include EFT information. The financial information segment (BPR) will include the following fields:

BPR05-PAYMENT-FMT-CDE	BPR10-DSS-EIN-NUM
BPR06-DFI-NUM-QUAL	BPR12-PROV-NUM-QUAL
BPR07-FLEET-ABA-NUM	BPR13-PROV-ABA-NUM
BPR08-ACCNT-NUM-QUAL	BPR14-PROV-ACCT-TYP
BPR09-DSS-ACCT-NUM	BPR15-PROV-ACC-NUM

We appreciate your cooperation as DSS moves towards a more efficient and cost effective means of reimbursement for Connecticut Medical Assistance Program services.

This bulletin and other program information can be found at **www.ctmedicalprogram.com**.
Questions regarding this bulletin may be directed to the EDS Provider Assistance Center - Monday through Friday from 8:30 a.m. to 5:00 p.m. at:

In-state toll free..... **800-842-8440** or
Out-of-state or in the
local New Britain, CT area **860-832-9259**

EDS
PO Box 2991
Hartford, CT 06104

Connecticut Medical Assistance Program
Authorization for Electronic Funds Transfer (EFT)*

Complete the section below and attach a copy of a voided check for a checking account, a deposit slip for a savings account or documentation from your banking institution confirming the bank account and routing number that will be utilized for the EFT deposit. The bank transit routing number, also known as the American Banking Association (ABA) routing number can be obtained from your bank.

Type of Authorization **NEW _____** **CHANGE _____**

PROVIDER NUMBER	PROVIDER NAME
BANK NAME	**BANK TRANSIT ROUTING/ABA NUMBER**
ACCOUNT NUMBER	**TYPE OF ACCOUNT**
	CHECKING _____ SAVINGS_____

I agree to keep, and disclose upon request to authorized agencies, records that disclose fully the extent of payments claimed from the services rendered to clients of the Connecticut Medical Assistance Program. I accept as payment in full the amount paid by the Connecticut Medical Assistance Program for claims submitted with the exception of authorized cost sharing by recipients. I understand payment of this claim is from state and federal funds and that any false claims, statements, documents or concealment of a material fact may be prosecuted under state or federal law. This is to certify that the information submitted to obtain this payment is true, accurate and complete.

I authorize the electronic transfer of Connecticut Medical Assistance Program payments made to the above provider number(s). I understand that I am responsible for the validity of the above information.

_____ _____
Contact Name Address

_____
Email Address

_____ _____
Signature Date

Return this form to:
EDS
P.O. Box 5007
Hartford, CT 06104

***Please Note:** Connecticut Medical Assistance Program providers who are currently enrolled in EFT are not required to complete this form.