

MEDICAID OFFERS ELECTRONIC FUNDS TRANSFER FOR PROVIDER PAYMENTS

The New York State Department of Health along with their eMedNY contractor, Computer Sciences Corporation (CSC), is pleased to announce the availability of eMedNY Electronic Funds Transfer (EFT). Providers who enroll in EFT will have their Medicaid payments directly deposited in their checking account. Savings accounts are not permitted.

Please note that EFT does not waive the two-week lag for releasing Medicaid disbursements.

To enroll in EFT, providers must complete the EFT PROVIDER ENROLLMENT FORM that can be found in this document along with detailed instruction for the completion of the form. Prior to completing the form, please carefully read the INSTRUCTIONS SHEET and follow its directions.

Please note that a defaced, original check from your checking account is required. Savings accounts are not permitted. Providers with multiple provider ID numbers must complete one application form for each ID and attach an original, defaced check to each application. Providers whose Medicaid payments are made to a Group Provider ID, need only complete an enrollment form for the Group ID number. EFT enrollment applications that do not conform to these instructions will be rejected.

After sending the EFT PROVIDER ENROLLMENT FORM to CSC, please allow a minimum time of 6 to 8 weeks for processing. During this period of time you should review your bank statement and look for an EFT transaction in the amount of \$0.01, which CSC will submit as a test. Your first real EFT transaction will take place approximately 4 to 5 weeks later.

If you have any questions about the EFT process please call eMedNY Call Center at 800-343-9000.

INSTRUCTIONS FOR ELECTRONIC FUNDS TRANSFER (EFT) ENROLLMENT

Providers wishing to request EFT of New York Medicaid funds must complete an EFT Provider Enrollment Form and mail the request form, along with a blank check from the checking account to which the funds are to be transferred. The check must be defaced. That means the word “VOID” must be written across the face of the check. The check must also contain the name and address of the provider or provider organization.

Sections A and B of the EFT form must be complete and legible, otherwise the request will not be processed and will be returned.

Section A: Provider Information

Step 1 – Enter the Medicaid Provider ID (or group ID if payment is made to a group practice). Enter only one provider ID per form. Providers with multiple provider IDs must submit a separate EFT Enrollment form for each provider ID number and attach an original, defaced check to each application. Provider Groups should enter the group ID only.

Step 2 – Enter the provider’s name and address exactly as it was filed with Medicaid. This is the address as it appears on your current checks and remittance statements, if any.

Step 3 – Provide a contact name and telephone number, email (if available) and fax number should additional information be required.

Step 4 – Enter the Tax ID supplied to Medicaid at the time of your enrollment. For established providers this can be found on your 1099 form.

Section B: Banking Information

Step 5 – Enter the routing number and account number for the checking account to which funds are to be transferred. Both numbers can be found at the bottom of your check.

Step 6 – Enter the name and address of the banking institution to which funds are to be transferred.

Step 7 – The form must be completed with an original signature and date of the provider or designated facility representative.

Section C: For CSC Use Only

Providers should leave this section blank.

EFT Enrollment forms should be mailed to:

Attention: EFT Processing
Computer Sciences Corporation
1 CSC Way
Rensselaer, NY 12144

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

Please contact your banking institution with questions about the availability of funds.

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.

Please note: If you are currently on check pick-up with NY Medicaid, once you are switched to EFT, your Medicaid remittance will be mailed to the pay-to address on file.



Mail to: **Computer Sciences Corporation**
Attn: EFT Processing
1 CSC Way
Rensselaer, NY 12144

EFT PROVIDER ENROLLMENT FORM

Section A: Provider Information

Provider ID #: _____
 Provider Name: _____
 Pay to Address: _____
 City: _____
 State: _____ Zip: _____
 Contact Person: _____ Phone #: _____
 eMail Address: _____ Fax #: _____
 Provider Tax ID#: _____

Section B: Banking Information

Routing #: _____ Account #: _____
 Account Type: **Checking**
 Bank Name: _____
 Address: _____
 City: _____
 State: _____ Zip: _____

****CSC as the eMedNY 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****

 Provider Signature and Title (Required) _____
 Date (Required)

Section C: For CSC Use Only

Date Received: _____
 Pick Up Indicator: No Yes Facility Location: _____
 Processed by: _____ Date: _____
 Authorized by: _____ Date: _____
 EFT Authorization Indicator: No Yes
 Effective Start Date: _____ Cycle #: _____