

State of Colorado
**AUTHORIZATION AGREEMENT
FOR AUTOMATIC DEPOSITS (ACH CREDITS)**

Agency ID UHA

Check one:

New Change

I (we) hereby authorize the Department of Health Care Policy & Financing, State of Colorado, hereinafter called STATE, to initiate credit entries and, if necessary, reverse any incorrect EFT credit entries made in error to our bank account indicated below.

MEDICAID PROVIDER # _____

NATIONAL PROVIDER IDENTIFIER # _____

PROVIDER LEGAL NAME _____

PROVIDER DBA NAME _____

Complete one of the following (EIN or SSN) but not both

FEDERAL EIN NUMBER

(Corporation, partnership, trust, sole proprietor, etc.) _____ - _____

SOCIAL SECURITY NUMBER

(Individual or sole proprietor) _____ - _____ - _____

ADDRESS _____

CITY, STATE, ZIP _____

FINANCIAL INSTITUTION INFORMATION

FINANCIAL INSTITUTION NAME _____

FINANCIAL INSTITUTION ADDRESS _____

CITY, STATE, ZIP _____

FINANCIAL INSTITUTION TRANSIT NUMBER _____

ACCOUNT NUMBER _____

TYPE OF ACCOUNT (CHECK ONE)

CHECKING
Attach voided check or bank letter

SAVINGS
Attach bank letter

This agreement is to remain in full force and effect until the STATE has received written notification from the PAYEE of its termination in such time and manner to afford STATE and FINANCIAL INSTITUTION a reasonable opportunity to act on it. It is the responsibility of the PAYEE to fill out a new agreement if the PAYEE changes banks or accounts.

Date _____ Phone number _____

Authorized Signature _____

Print Name _____

Title _____

Other contact name _____ Phone number _____

Completion Instructions

State of Colorado
**AUTHORIZATION AGREEMENT
 FOR AUTOMATIC DEPOSITS (ACH CREDITS)**

Agency ID UHA

Check one:
 New Change

I (we) hereby authorize the Department of Health Care Policy & Financing, State of Colorado, hereinafter called STATE, to initiate credit entries and, if necessary, reverse any incorrect EFT credit entries made in error to our bank account indicated below.

MEDICAID PROVIDER # Enter your 8-digit provider #

NATIONAL PROVIDER IDENTIFIER # Enter your 10-digit NPI #

PROVIDER LEGAL NAME Enter the legal name assigned to the Federal EIN or SSN below.

PROVIDER DBA NAME Optional – You may enter the DBA or trade name for corporation, sole proprietor, etc.

Complete one of the following (EIN or SSN) but not both

FEDERAL EIN NUMBER Complete for corporations, partnerships, etc. Enter the EIN assigned to the legal name entered above.
(Corporation, partnership, trust, sole proprietor, etc.)

SOCIAL SECURITY NUMBER Complete for individuals or sole proprietors. Enter the SSN assigned to the legal name entered above.
(Individual or sole proprietor)

ADDRESS Enter the mailing address for the legal name entered above.

CITY, STATE, ZIP Enter the City, State and Zip for the legal name entered above.

FINANCIAL INSTITUTION INFORMATION

FINANCIAL INSTITUTION NAME Enter the name of the financial institution where the funds will be transferred.

FINANCIAL INSTITUTION ADDRESS Enter the address of the financial institution.

CITY, STATE, ZIP Enter the City, State and ZIP for the financial institution.

FINANCIAL INSTITUTION TRANSIT NUMBER Enter the 9-digit number from your voided check (see illustration below) or contact your financial institution for information

ACCOUNT NUMBER Enter the account number where the funds will be deposited

TYPE OF ACCOUNT (CHECK ONE) CHECKING Attach voided check or bank letter SAVINGS Attach bank letter

Enter a check mark to identify the type of account where the funds will be deposited.

This agreement is to remain in full force and effect until the STATE has received written notification from the PAYEE of its termination in such time and manner to afford STATE and FINANCIAL INSTITUTION a reasonable opportunity to act on it. It is the responsibility of the PAYEE to fill out a new agreement if the PAYEE changes banks or accounts.

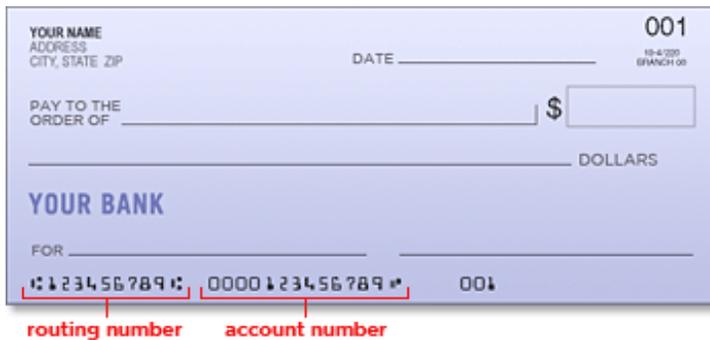
Enter the date the
 Date form is signed. Phone number Enter your telephone number.

Authorized Signature This must be the signature of the individual or sole proprietor if an SSN is used or the authorized representative of a corporation, partnership, etc.

Print Name Printed name of signer above.

Title Enter the title of the authorized representative of a corporation, partnership, etc.
Alternative person to contact other

Other contact name then listed above. Phone number Alternative person's telephone number.



**Account Number
Illustration**

Submission Instructions

Please send:
this completed form,
a voided check or bank letter,
and a copy of your W-9

To:
Xerox State Healthcare
Attn: Provider Enrollment
P.O. Box 1100
Denver, CO 80201-1100

Xerox State Healthcare does **not** have access to the voided check or W-9 you may have submitted with your Online Provider Enrollment tool application. Failure to submit a W-9 **and** voided check or bank letter with this form, **will result in an EFT delay until these items are received.**