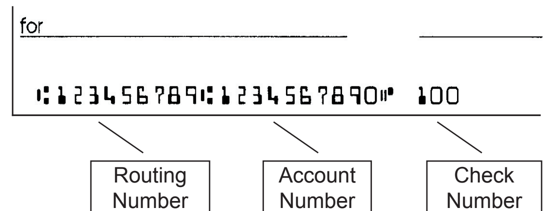
# Direct Deposit Authorization Form Instructions

*Provider: Please read before completing and signing this form.*
*Only enrolled DMAP providers may request Direct Deposit.*

**Type of Action:**
Select one of the following choices. Indicate the reason for cancellation or change in the appropriate field.
**New:** For new enrollment or for re-enrollment after cancellation.
**Change:** To change your Financial Institution and/or account number or account type (checking/savings), complete a new form. **To change** your contact information, mail information including name and DMAP provider number with authorized signature to the address listed below.
**Cancel**: To withdraw authorization for EFT/direct deposit payments.

**Part A: Provider Information**
1-3) **Name and Address**: Since there is a small possibility that a payment may have to be mailed to you, an address must be provided. This is the mailing address where you receive payments against your invoices.
4) **DMAP Provider #:** Enter your 6-digit Oregon Medicaid provider number in this field.
5) **E-mail Address:** Important information that must be received by you the same business day and may require a response.
6) **Phone & Fax Number:** So we can contact you during business hours in case there are any problems setting up this service or delivering a future payment to you.

**Part B: Account Information**
1-3) **Institution Name**, Phone Number, Address
4) **Account Type:** Specify if Checking, Savings or Local Government Investment Pool (LGIP).
5) **ABA Routing & Transit Number**: This is always a nine-digit number. See the check numbering example to the right.
6) **Depositor Account Number**: This may have up to seventeen digits. See example at right. Attach a cancelled check or deposit slip to the DMAP 3077 unless this is an LGIP.




7) **Account Name** (for commercial accounts)
8) **A cancelled check or account verification letter from the bank must accompany this application.**

**Part C: Authorization/Signature**
Read and sign the form to indicate your agreement with the terms and conditions specified on it. Note that by submitting the form you are authorizing the State of Oregon to credit your account (deposit funds) and, in the event of an overpayment error, to debit your account (withdraw funds) for the amount of the overpayment. All of the individuals named on a Consumer Account must sign this form. If held by more than one person, the joint account holder must also authorize these EFT transactions. You are also confirming that your Financial Institution is capable of processing EFT transactions.

**CANCELLATION / CHANGE OF ACCOUNT**
The agreement represented by this authorization remains in effect until canceled in writing by the payee or until the program is suspended or terminated by the State of Oregon. Payments to you will be deposited into the account designated in Part B of this form until DMAP is notified in writing that you wish to cancel this authorization or designate a different Financial Institution or account. Six to ten banking days are needed to execute your instructions. To make any changes, submit a new form (DMAP 3077) with the updated information. If any action or inaction taken by the payee results in non-acceptance of an EFT deposit by the designated Financial Institution, payee acknowledges that the State has no responsibility to issue another payment until the funds for the non-accepted deposit are returned to the State by the Financial Institution. If non-acceptance by the Financial Institution is the result of action or inaction taken by the payee, late fees and penalties including consequential damages caused by this non-acceptance do not apply. Please DO NOT CLOSE YOUR ACCOUNT UNTIL ONE WEEK AFTER NOTIFYING DMAP.

**RECOVERY OF FUNDS DEPOSITED IN ERROR**
In the event that an erroneous EFT payment occurs, creating an overpayment, the State reserves the right to debit your account for an amount not to exceed the amount of the erroneous EFT payment. In the event that a debit adjustment cannot be implemented, the State and/or Agency Office may utilize any other lawful means to recover payments to which the account holder is not entitled, including deducting the amount owed from future payments until the total overpayment is recovered.By signing Part C of this form, account holder(s) acknowledge their acceptance of these terms and conditions.

**Review all fields carefully:** Incomplete or missing information will delay the processing of this form. DMAP will not accept stamped signatures.

**Return completed form by CERTIFIED MAIL to:**
DMAP Health Financing Operations
ATTN: ACH Coordinator - CONFIDENTIAL
500 Summer St NE, E44, Salem, OR 97301-1078

**If you have any questions:**
Call DMAP at (800) 422-5047
and ask for DMAP's ACH Coordinator.

DHS
Oregon Department of Human Services

Division of Medical Assistance Programs

# Direct Deposit Authorization Form

For Receiving Medicaid Payments by Electronic Funds Transfer (EFT)

**Read instructions before completing - Print or Type**

| **Type of Action** ❑ New ❑ Change ❑ Cancel | Reason for cancellation or change: |
|---|---|

## A. Provider Information

| 1 Last Name First Name Middle Initial | 2 Business Name |
|---|---|
| 3 Mailing Address<br>City State ZIP | 4 DMAP Provider # |
| 5 E-mail Address | 6 Phone Number & Fax Number (include area code) |

## B. Account Information

| 1 Institution Name | 2 Institution Phone Number (include area code) |
|---|---|
| 3 Mailing Address | 4 Account Type:<br>❑ Savings ❑ Checking ❑ LGIP |
| City State ZIP | 5 Account Routing and Transit Number |
| 6 Depositor Account Number (Attach a cancelled check or verification letter) | 7 Account Name (for commercial accounts) |

## C. Authorization/Signature *(1=Primary Account Holder, 2=Joint Account Holder)*

I/We certify that I/we have read and understand the information contained in Part C of the form instructions. I/We authorize the State of Oregon, through the State Treasury, to deposit payments and make overpayment adjusting debits to my/our account as designated above. I certify that I am authorized to enter into this agreement on behalf of the account holder. I/We have also verified that this Financial Institution is ACH capable and will comply with NACHA rules. ACH payments credited to the above account will be available to the account holder at the start of the Financial Institution's business day on the settlement date established by the ACH operator.

| 1a Last Name First Name Middle Initial | 1b Title (required if company acct ) |
|---|---|
| 1c Signature | 1d Date |
| 2a Last Name First Name Middle Initial | 2b Title (required if company acct ) |
| 2c Signature | 2d Date |

## DMAP Use Only

| 1. Vendor # and Mail Code | 2. Pre-Note Date | 3. NACHA Format | 4. Notes |
|---|---|---|---|
| | | **PPD+ CCD+ CTX** | |