AmericasHealth Plan

ELECTRONIC FUNDS TRANSFER (EFT)
For Provider Payments

AmericasHealth Plan (AHP) is pleased to announce the availability of Electronic Funds Transfer (EFT). Providers who enroll in EFT will have their payments deposited directly into their checking or s savings account. The EFT option is available only to in-network providers.

To enroll in EFT, providers must complete the **EFT PROVIDER ENROLLMENT FORM** that can be found at the end of this document. Prior to completing the form, please read the INSTRUCTION SHEET carefully and follow the directions.

Providers with more than one National Provider ID (NPI) should attach a list of NPI numbers to the application.

Please note that any attachments to the EFT application must have original signatures.

Provider Groups that receive payments under the Group ID need only to complete a single enrollment form for the Group NPI. However, members of Provider Groups who also bill individually may enroll by submitting a separate enrollment form using their individual Provider NPI.

The following items must be attached to your enrollment form:

- A voided check from your checking account.
- Submit a letter from a bank officer verifying your account information. The letter must be on bank letterhead and include the bank's name, address and routing number, the type of account, the account number, and the account owner's name, address and tax ID number. The letter also must be signed by a bank officer.
- W9 form

EFT enrollment applications that do not conform to these instructions will be rejected.

After sending the EFT PROVIDER ENROLLMENT FORM to AHP, please allow a minimum of 6 to 8 weeks for processing.

The EFT transactions will be initiated on Wednesdays. But due to normal banking procedures, the transferred funds may not be available for up to 7 days after the transfer. Please contact your banking institution regarding the availability of your funds.

If you have any questions about the EFT process, please contact your Provider Relations Representative at 1-800-633-3313 ext. 8620.

INSTRUCTIONS FOR ELECTRONIC FUNDS TRANSFER (EFT) ENROLLMENT

Providers wishing to request EFT of AHP funds must complete an EFT Provider Enrollment Form and mail it along with a blank check from the checking account to which the funds are to be transferred. The check must contain the name and address of the provider or provider organization and the word "VOID" must be written across its face.

OR

If you have a deposit-only checking account (and you do not have checks) or you choose to have the EFT deposited into a savings account, you may submit a letter from a bank officer. The letter must be on bank letterhead and include the bank's name, address and routing number, the type of account, the account number, and the account owner's name, address and tax ID number. The letter also must be signed by a bank officer.

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 provider's name as it is filed with AHP. This is the name as it appears on your current checks and remittance statements, if any.

Step 2 – Enter the National Provider ID (or group NPI if payment is made to a group practice). Providers with more than one NPI, attach a list of NPI numbers to the application. **Provider Groups that receive payments under the Group number need only to complete a single enrollment form for the Group NPI.** However, members of Provider Groups who also bill individually may enroll by submitting a separate enrollment form using their individual provider number.

Step 3 – Enter the name of the main contact person.

Step 4 – Enter the phone number of the contact person.

Step 5 – Enter the provider's service address, city, state and zip.

Step 6 – Enter the AHP Provider ID Number (it must match the number registered with AHP).

Step 7 – Enter the Tax ID number.

Step 8 – Enter the email address of the contact person.

Section B: Banking Information

Step 9 – Enter the routing number and the account number for the checking or savings account to which funds are to be transferred. Both numbers can be found at the bottom of your check.

Step 10 – Enter the name and address of the banking institution to which funds are to be transferred.

Step 11 – The form must be completed with the original signature of the provider or the designated facility representative and the date it was signed.

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Section C: EFT Authorization or Cancellation

Providers should complete and sign this section. All documents received will be processed and placed in the provider's file.

Please note: For providers who have claims paid within a particular payment cycle, funds are normally scheduled to be transferred on Wednesday afternoons. Due to normal banking procedures, the funds may not become available in the provider's account for up to 48 hours from the initial transfer. Please contact your banking institution with questions about the availability of funds.

Please allow a minimum of 6 to 8 weeks for your request to be processed.

To change banking information, providers must send the following:

- A new EFT enrollment form indicating the new banking information. The enrollment form must be signed with an original signature and a title must be indicated.
- A voided check with the new account and routing numbers must be attached to the new enrollment form. If theaccount is a "deposit only" account, attach a signed, notarized letter from your banking institution indicating the new account and routing numbers. Regardless of what is being updated, both the account and routing numbers must always be indicated.
- A letter indicating changes to your account is required. The letter must be on company letterhead and include any provider number(s) (tax ID and NPI), new account and routing numbers and a brief explanation for the change. The letter must have an original signature and a title should be indicated.

Note: If you are changing your EFT from one banking institution to another banking institution, your payments will automatically transfer back to paper for a two week time frame while your EFT is being set up on your new account.

To cancel EFT transactions, providers must send an EFT authorization form, including the provider number(s), applicable Tax ID and/or NPIs, to the address below. Please allow 6 to 8 weeks to transition to a paper check.

Email or Mail the completed form with the voided check and attachments (if applicable) to:

Email: ProviderRelations@americashp.com
ATTN: AHP EFT (DBA/Provider name)

OR

Mail: AmericasHealth Plan, Attention: EFT Processing - Provider Relations Dept.
1000 Town Center Dr. Suite 410 Oxnard, CA 93036

Questions about form completion should be directed to AHP Provider Relations at 1-800-633-3313 ext. 8620.

ELECTRONIC FUND TRANSFER AUTHORIZATION

AmericasHealth Plan: This authorization remains in full force and effect until AHP receives written notification from the provider of its termination, or until AHP or an appointing authority deems it necessary to terminate the agreement.

DIRECTIONS: An original pre-imprinted voided check for checking accounts, or an original bank letter for savings accounts, must be submitted with this form. The provider name, routing number and account number on either of those documents must match what is entered on this form. Photo-copied documents will not be accepted. *Use blue or black ink for signatures.*

SECTION A: PLEASE PRINT OR TYPE

1. NAME OF PROVIDER (must match name on bank account and name registered with AHP)			2. NPI NUMBER (one EFT form per number)
3. NAME OF MAIN CONTACT PERSON			4. TELEPHONE NUMBER
5. PROVIDER SERVICE ADDRESS	City	State	Zip
6. AHP PROVIDER ID NUMBER (must match number registered with AHP)	7. TAX ID NUMBER	8. EMAIL ADDRESS	

SECTION B

1. BANK ROUTING NUMBER	2. BANK ACCOUNT NUMBER (include leading zeros)	3. TYPE OF ACCT ☐ CHECKING	☐ SAVINGS
4. BANK NAME			
5. BANK ADDRESS	City	State	Zip

SECTION C (Check the appropriate box)

☐ I hereby authorize AmericasHealth Plan to initiate credit entries to my bank account as indicated above, and the depository named above to credit the same to such account. For changes to existing accounts, do not close an existing account until the first payment has been deposited into the new account.

☐ I hereby **CANCEL** my EFT authorization.

I understand that by signing this form, payments issued will be from Federal and State funds, and that any falsification or concealment of a material fact may be prosecuted under Federal and State laws.

Provider Signature:_____ Date:_____
(PRINT the form, sign it in BLUE or Black INK ONLY - must be owner or corporate officer - and send it via mail or email.)

Mail This Form To:
AmericasHealth Plan
ATTN: EFT Processing - Provider Relations Dept.
1000 Town Center Drive Suite 410
Oxnard, CA 93036

Email Only:
ATTN: AHP EFT [DBA/PROVIDER NAME]
ProviderRelations@americashp.com

Privacy Statement (Civil Code Section 1798 et seq.): The information requested on this form is required by AmericasHealth Plan for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your request being delayed or not processed.