healthfirst
Health Insurance for New Yorkers

Electronic Funds Transfer (EFT) Authorization Agreement

DESCRIPTION

The Electronic Funds Transfer (EFT)/Electronic Remittance Advice (ERA) program offers convenient services that allow direct deposit and automated documentation of Healthfirst New York (HFNY) claim payments. With EFT, reimbursements are wired directly into the vendor's checking account, which means no lost checks, no deposit slips to prepare, and no waiting for checks to clear. ERA is a digital Explanation of Payment (EOP), an electronic statement that reduces paperwork and allows the vendor to easily reconcile reimbursements to their patient accounts.

HOW TO OBTAIN FORMS

A provider may obtain the EFT form only from the following sources:

- **www.healthfirst.org/providers** — Requires User Account Registration
- Applicable Network Account Manager for In-Network Providers

WHERE TO SUBMIT COMPLETED DOCUMENTATION

Email: **HFEFTERA@Healthfirst.org**
Fax: **1-646-313-4635**
Mail: Provider Operations and Reimbursement
P.O. Box 5168, New York, NY 10274-5168

EFT PROCESS COMPLETION GUIDE AND ADDITIONAL INFORMATION

This form is to be used to enroll, change, or terminate your EFT. Use the following guide as well as the glossary when completing your EFT enrollment form to ensure it is completed correctly.
Fields with an asterisk are required; sections left blank or that are illegible will delay processing and may result in a rejection.

If you are enrolling in EFT for the first time, ERA setup/enrollment is required with our clearinghouse **Change Healthcare** before EFTs can be approved. Please use Change Healthcare's self-service enrollment portal to add our payer ID (80141). If you or your vendor/clearinghouse do not have on-line access to the Change Healthcare portal, a hard-copy **ERA Remittance Form** can be submitted (refer to page 5).
For any ERA related questions/inquiries, please contact Change Healthcare for assistance:
Telephone Number: **1-866-924-4634**
Email: **batchenrollment@Changehealthcare.com**
Website: **Change Healthcare Enrollment Services**

- EFT/ERA requests may take as many as to 30 days to process. Delays with clearinghouse account setup or missing information may increase processing time
- EFT/ERA forms must be completed and signed only by the provider associated with the Tax ID Number indicated on the form or by a verifiable, authorized employee/representative empowered to make bank account changes on the provider/organization's behalf
- EFTs are processed by Tax ID. Only one EFT authorization form is to be filled out per Tax ID. This requires that all providers under said Tax ID have the same banking routing and account information as all providers under said Tax ID will be updated with the same information
- The information submitted on an EFT/ERA form is subject to verification with the listed provider and banking entity
- If Healthfirst is unable to verify the validity of the requested account setup and/or change, the request will be rejected and a rejection letter will be sent to the provider's address
- Include a copy of a voided check or a bank letter that is no older than 60 days. These items need to be imprinted with the provider's/organization's name, provider's address, routing number, and account number, and need to match what is listed on the EFT form.

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An asterisk (*) indicates required fields within each section. Incomplete and/or illegible fields and signatures will cause your enrollment to be delayed. Refer to instructions before completing this form.

PROVIDER INFORMATION

*Provider Name	Trading Partner ID (Healthfirst Provider ID)
*Provider Street Address	*City *State *ZIP Code

PROVIDER IDENTIFIERS INFORMATION

*Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	*National Provider Identifier (NPI)

*Provider Type

☐ Ancillary ☐ Hospital ☐ Physician ☐ Physician Group ☐ Other _____

PROVIDER CONTACT INFORMATION

*Provider Contact Name	*Title
*Telephone Number	*Email Address

FINANCIAL INSTITUTION INFORMATION

I hereby authorize Healthfirst, called COMPANY, to initiate credit entries and, if necessary, adjustments for any credit entries to the account indicated below and the depository named below, hereafter called DEPOSITORY, to credit the same to such account.

*Financial Institution Name	*Name on Account with Financial Institution
*Financial Institution Routing Number	*Type of Account at Financial Institution ☐ Checking ☐ Savings
*Provider's Account Number with Financial Institution	*Account Number Linkage to Provider Identifier ☐ Provider Federal Tax Identification Number (TIN)

SUBMISSION INFORMATION

*Reason for Submission

☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

AUTHORIZATION AGREEMENT AND SIGNATURE

The undersigned hereby certifies that the information provided herein is true and accurate and that he/she has been authorized by PROVIDER to execute this agreement on behalf of PROVIDER to form a legally binding contract, and understands that acceptance of this Agreement constitutes an agreement to be bound to perform in strict conformity with all contracts between PROVIDER and COMPANY, and all applicable laws and regulations. This Authorization remains in full force and effect until COMPANY has received written notification from PROVIDER's duly authorized representative(s) of PROVIDER's termination. Such notification shall be provided in writing and in enough time to provide the COMPANY a reasonable opportunity to operationally and otherwise conclude activities related to the termination.

*Printed Name of Authorized Person Submitting Enrollment	*Printed Title of Authorized Person Submitting Enrollment
*Signature of Authorized Person Submitting Enrollment	*Submission Date

Completed forms can be submitted as follows:

Email: **HFEFTERA@Healthfirst.org**
Fax: **1-646-313-4635**
Mail: Provider Operations and Reimbursement
P.O. Box 5168, New York, NY 10274-5168

Please direct all questions to:
Telephone Number: **1-888-801-1660**

This form is prohibited from being published anywhere other than the Healthfirst Provider Secure Services website.

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EFT Authorization Form Glossary/Rules

ELEMENT NAME	ELEMENT DESCRIPTION
PROVIDER INFORMATION	
Provider Name	Complete legal name of institution, corporate entity, practice, or individual provider. *Needs to match the provider/organization name tied to the bank account provided.
(Trading Partner ID) Healthfirst Provider ID	Provider ID assigned to the provider by Healthfirst.
Provider Street Address	The number and street name where a person or organization can be found. *This needs to be the same address provided on the ERA form.
City	City associated with provider address field.
State	ISO 3166-2 two-character code associated with the state/province/region of the applicable country on the ERA form.
Zip Code	System of postal-zone codes.
PROVIDER IDENTIFIERS INFORMATION	
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity. *This needs to be the TIN for the provider/organization signing up for EFT.
National Provider Identifier (NPI)	A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions. *This needs to be the NPI of the provider/organization signing up for EFT. If the TIN is linked to an individual provider, the individual NPI is to be provided. If the TIN is linked to a group organization, the group NPI is to be provided.
Provider Type	A proprietary health plan-specific indication of the type of provider being enrolled for EFT with specific provider type description included by the health plan in its instruction and guidance for EFT enrollment (e.g., hospital, laboratory, physician, pharmacy, pharmacist, etc.)
PROVIDER CONTACT INFORMATION	
Provider Contact Name	Name of a contact in provider office for handling EFT issues.
Title	Title of contact person.
Telephone	Telephone number associated with contact person.
Email Address	An electronic mail address at which the health plan might contact the provider.
FINANCIAL INSTITUTION INFORMATION	
Financial Institution Name	Official name of the provider's financial institution.
Name on Account with Financial Institution	Name that the Bank Account was opened under. *This needs to match the Name that is listed on the Voided Check/Bank Letter.
Financial Institution Routing Number	A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited.
Type of Account at Financial Institution	The type of account the provider will use to receive EFT payments (e.g., checking, saving).
Provider's Account Number with Financial Institution	Provider's account number at the financial institution to which EFT payments are to be deposited.
Account Number Linkage to Provider Identifier	Provider preference for grouping (bulking) claim payments – must match preference for v5010 X12 835 remittance advice. *The account number provided needs to be linked to the TIN provided, as EFT is set up by TIN.

SUBMISSION INFORMATION	
Reason for Submission	EFT submission reason (e.g., new, change, or cancel enrollment).
AUTHORIZATION AGREEMENT AND SIGNATURE	
Printed Name of Authorized Person Submitting Enrollment	The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment.
Printed Title of Authorized Person Submitting Enrollment	The printed title of the person signing the form; may be used with electronic and paper-based manual enrollment.
Signature of Authorized Person Submitting Enrollment	The signature of an individual authorized by the provider or its agent to initiate, modify, or terminate an enrollment. May be used with electronic and paper-based manual enrollment.
Submission Date	The date on which the enrollment is submitted. *EFT forms are no longer valid after 60 days.

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CHANGE HEALTHCARE

Send completed form to:
Batchenrollment@changehealthcare.com
Fax: (615) 885-3713

Remittance

Payer Information

CPID	Payer ID	Payer	Type	Est Days	Multi CH
1854	80141	HEALTHFIRST of NEW YORK	Professional	30	No

Special Enrollment Instructions

Payer requires providers to enroll for EFT in order to recieve electronic remittance.

A copy of a voided check or a letter from the bank is required with enrollment.

Enrollment can be faxed to Change Healthcare at 615-885-3713.

Remittance will be setup in the Change Healthcare system within 10 days. The payer will work directly with the provider to setup EFT. Change Healthcare is not informed when EFT is setup and remittance will start once EFT has been setup. Please contact Healthfirst of NY at 1-888-801-1660 for EFT status.

Vendor Information

Submitter ID	Submitter Name

Provider Information

Tax ID	NPI	Provider Number	Name

Address	City	State	Zip

Contact Name	Contact Phone

Contact Email Address

Confirmation Addresses

Primary Email Address	Secondary Email Address
	HFEFTERA@Healthfirst.org

ERA Receiver

Distribution Detail

For Change Healthcare use only