Indiana First Steps
Early Intervention
Central Reimbursement Office

Electronic Funds Transfer (EFT)

The Indiana First Steps program provides a safe, easy, and trouble-free way for you to receive your payments. Direct Deposit places your payments electronically into your checking account instead of having to wait to receive your check by mail.

If you elect to receive payments electronically, all funds must be designated to **one** account.
Negative balances at month end will not be debited from your checking account. The negative amount will be deducted from future payments.
Erroneous credits that can be debited from your account refer only deposits that were made in error.

Authorization/Change
I hereby authorize the Indiana First Steps-Central Reimbursement Office, hereinafter called FSSA-CRO, to initiate credit entries, and debit entries for any erroneous credit, to the following bank account (checking accounts only).

Payee Information:

Payee Name:_____ FEIN/Social Security Number:_____

Payee Address:_____

City:_____ State:_____ Zip: _____

Payee Telephone Number: _____

Financial Institution Name: _____

Financial Institution Address:_____

Financial Institution Phone Number:_____ Type of Account: _____ Savings _____Checking

Account Information: Attach a voided or canceled check. A copy is acceptable.

Name on Account:_____

Type of Authorization: _____ Start _____ Cancel _____ Change

Routing Number									

Account Number																	

On behalf of the provider entity named above, I agree to keep, and disclose upon request to authorized agencies, records that fully disclose the extent of claim payments received from and services rendered to members of the Indiana Health Coverage Programs (IHCP). I accept, as payment in full, the amount paid by the IHCP for claims submitted with the exception of authorized cost sharing by members. I understand payment of IHCP claims is from state and federal funds and that any false claims, statements, documents or concealment of a material fact may be prosecuted under state or federal law. I ensure that this EFT request complies with the regulation set forth in *42 CFR 447.10*, which prohibits State payments for any IHCP service to be made to anyone other than a Provider, a non-cash member, or to one of the listed exceptions. I understand that an IHCP payment may be sent via EFT to an account held by the following only: (1) to the Provider; (2) a non-cash member; (3) a government agency on reassignment by the Provider (IRS); (4) a third party **by court order** on reassignment by the Provider (child support); (5) a business agent (billing service, account firm) if three specific criteria are met (see page 2*); (6) the employer of the Practitioner (if a contract so requires); (7) a health care facility or a health care delivery system (if a contract so requires) if the organization itself submits the claim directly to the IHCP.

I authorize the electronic transfer of IHCP payments for all program elections to be made to the above provider number. I understand that I am responsible for the validity of the above information. I agree to notify CSC Covansys within ten days of any change in any of the information included on this form.

This authority is to remain in full force until FSSA-CRO has received notification from me of its termination in such time and in such manner as to afford FSSA-CRO and Depository a reasonable opportunity to act on it.

Furthermore, It is agreed that this agreement can be terminated by FSSA-CRO with reasonable notification to the party.

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The following Section must be completed by an authorized officer or owner of the billing provider.

Authorized Name:_____

Signature:_____ Date: _____

Billing Agents: *The following section must be completed if a billing agent is receiving payment on behalf of the provider. The **exception** for a business agent is limited to agents who furnish statements and receive payments in the name of the provider, and the service provided by the agent is: (1) related to the cost of processing the bill; (2) not related to a percentage or other basis to the amount billed or collected; and (3) not dependent upon the collection of payment. Further, a payment for a provider may not be made to or through an individual or organization (collection agency or service bureau), or by power of attorney thereof, that advances money for accounts receivable that a provider has assigned, sold or transferred to the organization for a fee or deduction of accounts receivable.*

Complete the section below if EFT funds will be paid to a Billing Agent's bank account and not the account of the Billing Agent.

Billing Agent Name: _____

Telephone Number:_____ Billing Agent's Tax ID:_____

Billing Agent Address:_____

Authorized Billing Agent Contact Name:_____ Title:_____

Authorized Billing Agent Signature:_____ Date:_____

Please Return Completed Form and Documentation to:

Mail: Attn: Provider Enrollment
Indiana First Steps – Central Reimbursement Office
P/O Box 29160
Shawnee Mission, KS 66201-9160

For CFO Use Only	Date Received	Date Entered	Entered by	Test Complete date