## ForwardHealth Portal Electronic Funds Transfer

March 11, 2024



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# **1** Introduction

This user guide provides general instructions on how to enroll in and administer a ForwardHealth electronic funds transfer (EFT) account.

## **1.1 Important Information**

The following information should be reviewed and understood prior to enrolling for EFT payments from ForwardHealth:

- All EFT enrollments must be completed via your secure Provider Portal account. Paper enrollments will not be accepted.
- Only a clerk who has been assigned the EFT role may enroll in EFT. An account administrator may create a new clerk account for this purpose or may modify an existing clerk account to have an EFT role.
- Once enrolled for EFT, organizations cannot revert back to receiving paper checks.
- Organizations may change their EFT information at any time.
- Enrolling in EFT does not change your Remittance Advice. You will continue to receive your remittance information the same way.

If you do not have a ForwardHealth Portal account and wish to enroll in EFT, go to <u>https://www.forwardhealth.wi.gov/</u> to request a ForwardHealth Portal account. You may also call the ForwardHealth Portal Helpdesk at 866-908-1363 for assistance in requesting a Provider Portal account.

## **1.2 Getting Started**

All administrative accounts have access to the EFT enrollment and tracking function on the ForwardHealth Portal.

Account administrators who wish to delegate EFT enrollment and tracking functionality to users within their organization can create clerk accounts, modify existing clerk accounts, and grant those clerk accounts access to the EFT enrollment and tracking functionality. The EFT role should only be assigned to those clerks who need access to EFT information and should be removed when no longer needed.

Note: Please be advised that EFT information includes data about your financial institution and EFT settlement account number. By granting a clerk the EFT role, account administrators are granting clerks access to this information. Account administrators are responsible for ensuring that access to this information is restricted to only those clerks authorized within the organization to view the information.

For information about managing clerk accounts, refer to the "Clerk Maintenance" section of the <u>ForwardHealth Provider Portal Account User Guide</u> which is located on the Portal User Guides page of the ForwardHealth Portal.

# **2** Enroll in Electronic Funds Transfer

1. Access the ForwardHealth Portal at <a href="https://www.forwardhealth.wi.gov/">https://www.forwardhealth.wi.gov/</a>.



Figure 1 ForwardHealth Portal Page

2. Click Login. A Sign In box will be displayed.

| ForwardHealth                  |  |
|--------------------------------|--|
| Sign In                        |  |
| Username                       |  |
| 1                              |  |
| Keep me signed in              |  |
| Next                           |  |
| Unlock account?                |  |
| Help                           |  |
| Logging in for the first time? |  |
|                                |  |

Figure 2 Sign In Box

- 3. Enter the user's username.
- 4. Click **Next**. A Verify with your password box will be displayed.

| ForwardHea          | lth    |
|---------------------|--------|
| ****                | )      |
| Verify with your pa | ssword |
| () PORTALUSE        | 81     |
| Password            |        |
| •••••               | 0      |
|                     |        |
| Verify              |        |
|                     |        |
|                     |        |
| Forgot password?    |        |

Figure 3 Verify With Your Password Box

5. Enter the user's password.

6. Click Verify. The Secure Provider page will be displayed.

| In the state agencies subject directory department of health services  |   |
|--|---|
| ForwardHealth<br>Wisconsin serving you Provider  | Welcome Inpatient03 UAT » May 7, 2019 2:35 PM<br>Logout   |
| Home         Search         Providers         Enrollment         Claims         Prior Authorization         Remittance Advices         Trade Files           Account         Contact Information         Online Handbooks         Site Map         User Guides         Certification   | Health Check Max Fee Home   |
| You are logged in with NPI: 1255334173, Taxonomy Number: 282N00000X, Zip Code: 53226, Financial<br>Payer: Medicaid<br>Providers  | Search  |
| What's New? Providers can improve efficiency while reducing overhead and paperwork by using real-time applications available on the new ForwardHealth Portal. Submission and tracking of claims and prior authorization requests and amendments, on-demand access to remittance information, 835 trading partner designation, and instant access to the most current ForwardHealth information is now available. | Orme Page     Update User Account     Customize Home Page     Demographic Maintenance     Electronic Funds Transfer     Check My Revalidation Date     Revalidate Your Provider Enrollment     Check Enrollment |
| New Rate Reform Part 3 Ideas/Recommendations Requested.  |   |
| Incentive Payments Are you Eligible?   |   |
| ForwardHealth System Generated Claim Adjustments   | Quick Links   |
|  | Register for E-mail Subscription  |

Figure 4 Secure Provider Page

7. Click **Electronic Funds Transfer** located in the Home Page box on the right of the page. The Introduction page will be displayed.

Note: Electronic funds transfer enrollment must be initiated by an account administrator or clerk who has been assigned the EFT role. Clerks not assigned the EFT role will not see the EFT link. Account administrators who wish to delegate the EFT enrollment and tracking functionality to other users within their organization can create clerk accounts, modify existing clerk accounts, and grant those clerk accounts access to the EFT enrollment and tracking functionality. For information on adding a role to a clerk, refer to the ForwardHealth Provider Portal Account User Guide.

| Introduction  |
|---|
| Required fields are indicated with an asterisk (*).   |
| For New EFT enrollments or Changes to Existing EFT Enrollments:   |
| You will need to have the following information available:  |
| <ul> <li>The name and email address for the person in your organization that will serve as the contact for al<br/>EFT information.</li> </ul>   |
| <ul> <li>The financial institution's ABA routing number.</li> <li>The account number and the name on record with the bank/financial institution as the Account<br/>Holder for the account.</li> </ul> |
| <ul> <li>The type of account (savings or checking, personal or business).</li> </ul>  |
| Existing EFT Data   |
| <ul> <li>Any existing EFT information will be pre-populated based on the current organization you are logged<br/>in with.</li> </ul>  |
| To Check the Status of Your EFT Enrollment:   |
| <ul> <li>Click "Next" below and a status screen will appear.</li> </ul>   |
| User Guide  |
| • <u>View</u> the EFT user guide.   |
| EFT Processing Overview   |
| <u>View</u> the EFT processing overview.  |
|   |
| Next Exit C   |

Figure 5 Introduction Page

8. Gather the information listed on the Introduction page. Your financial institution's American Bankers Association (ABA) routing number and the account number used for your EFT transactions can be found on the account's checks and deposit slips.

|                                | Account Number                     |
|--------------------------------|------------------------------------|
| Television of the              | 0000000 1001                       |
|                                |                                    |
| OP AN TO THE                   | IS                                 |
|                                | DOLLARS & REFE                     |
| YOUR FINANCIAL INSTITUTION USA | UTION                              |
|                                | -                                  |
| 000 000                        | 1234.56 ** 100.1                   |
|                                |                                    |
|                                |                                    |
|                                | —— 9-digit ABA Bank Routing Number |

Figure 6 Sample Check

9. Click **Next**. The Electronic Funds Transfer Request page will be displayed.

| Electronic Fund  | s Transfer Requ   | est                              |                               |                                   |  |  |                           |                |             |              | 3            |
|--|---|----------------------------------|-------------------------------|-----------------------------------|--|--|---------------------------|----------------|-------------|--------------|--------------|
| Required fields ar   | e indicated with a  | an aste                          | erisk (*)                     | ).                                |  |  |                           |                |             |              |              |
| <ul> <li><u>View</u> the E</li> <li>Select the</li> <li>Organization</li> <li>To view the</li> </ul> | FT user guide.<br>organization(s) ti<br>ns that currently<br>e audit history of | hat yo<br>have<br>an or <u>c</u> | u want<br>a pendi<br>ganizati | to add/o<br>ng statu<br>on, seleo | change the E<br>s can not be<br>ct the "View I | FT information.<br>changed.<br>History" button : | from the list below.      |                |             |              |              |
| Organization   | List  |                                  |                               |                                   |  |  |                           |                |             |              |              |
| Organizatio  | n List  | State                            | 710                           | $710 \pm 4$                       | Таховору                                       | Drovidor Type                                    | Daver                     | EET Status     | Add/Change  | _            |              |
| 000000000000000000000000000000000000000  | LADYSMITH   | WI                               | 54848                         | 210 + 4                           | 000N00000X                                     | Physician Group                                  | Medicaid                  | No EFT on file | Add/ change | View History |              |
| 000000002  | PLATTEVILLE   | WI                               | 53818                         | 1264                              | 100N00000X                                     | Hospital   | Medicaid                  | No EFT on file |             | View History |              |
| 000000003  | COTTAGE GROVE   | WI                               | 53527                         |                                   | 200N00000X                                     | Pharmacy   | Medicaid                  | Active         |             | View History |              |
| 000000004  | MIDDLETON   | WI                               | 53562                         |                                   | 300N00000X                                     | Dentist  | Medicaid                  | Active         |             | View History |              |
| 000000005  | LADYSMITH   | WI                               | 54848                         |                                   | 400N00000X                                     | Physician Group                                  | Medicaid                  | No EFT on file |             | View History |              |
| 000000006  | GREEN BAY   | WI                               | 54305                         |                                   | 500N00000X                                     | Hospital   | Wisconsin Chronic Disease | No EFT on file |             | View History |              |
|  |   |                                  |                               |                                   |  |  |                           |                |             |              | Select All M |
|  |   |                                  |                               |                                   |  |  |                           |                |             |              |              |
| Audit Histor   | /   |                                  |                               |                                   |  |  |                           |                |             |              |              |
| A well's 11 store  |   | _                                | _                             | _                                 |  |  |                           | _              |             | _            |              |
| *** No rows for  | Y<br>nd ***   | _                                | _                             | _                                 |  |  |                           |                |             |              |              |
|  |   |                                  |                               |                                   |  |  |                           |                |             |              |              |
|  |   |                                  |                               |                                   |  |  |                           |                |             |              |              |
|  |   |                                  |                               |                                   |  |  |                           |                |             |              |              |
|  |   |                                  |                               |                                   |  | Previous   | Next                      |                |             |              | Exit C       |

Figure 7 Electronic Funds Transfer Request Page

If you are an EFT clerk, this page will display all the service locations for which you are assigned the EFT role. Account administrators will see all the service locations for the provider under which they are logged in.

The EFT Status column displays the current status of each service location. Service locations not yet enrolled in EFT will display a status of *No EFT on file*.

10. Check the Add/Change box for each service location that is to be enrolled in EFT. If all the service locations listed are to be enrolled, click Select All.

Note: When more than one service location is selected, all the information entered in the succeeding pages will apply to all the service locations selected. If there is a difference in the EFT set-up information used between service locations, including demographic information, email addresses, ABA routing numbers, EFT settlement account numbers, and account types, the service locations must be entered separately.

11. Click **Next**. The General Information page will be displayed.

| General Information  |  | 9    |
|--|--|------|
| Required fields are indicated with   | an asterisk (*).   |      |
| <ul> <li><u>View the EFT User Guide</u></li> <li>If you need to change the</li> </ul>  | tax information below, please go to the <u>Demographic Maintenance Tool</u> to submit your new information through the portal. |      |
| Pay To Address   |  |      |
| Name - Business or Individual  | STATE UNIVERSITY   |      |
| Street Address Line 1  | 123 MAIN STREET  |      |
| Street Address Line 2  | MEDICAL FOUNDATION   |      |
| City   | ANYTOWN  |      |
| State/ZIP  | WI 🗸 55555 -   |      |
| Contact Information Name - Contact Person* Primary E-mail Address* Telephone Number* Fax Number Other EFT Contact Notificat E-mail Address 1 E-mail Address 2 E-mail Address 3 | ion Addresses  |      |
| E-mail Address 4   |  |      |
| Tax Identification Informatio  | on   |      |
| Taxpayer Identification Numbe  | r (TIN) 00000000   |      |
| Name - FEI   | IN/SSN IM A. PROVIDER  |      |
|  |  |      |
|  | Previous Next  | Exit |

Figure 8 General Information Page

The "Pay To Address" and "Tax Identification Information" sections are pre-filled with the information you already have on file.

Note: If it is necessary to change the tax identification information, click **Demographic Maintenance Tool** located at the top of the page to submit your new information.

12. In the "Contact Information" section, enter the name and contact information of the individual from your organization designated as the primary contact for all notices and information regarding EFT. The email address entered in the "Contact Information" section will serve as the primary email contact for the EFT account.

| Name - Contact Person*   | JANE DOE             |  |
|--|----------------------|--|
| Primary E-mail Address*  | jane.doe@abc.com     |  |
| Telephone Number*  | (123)456-7800 Ext.   |  |
| Fax Number   | (123)456-7801        |  |
| Other EFT Contact Not  | tification Addresses |  |
| Other EFT Contact Not<br>E-mail Address 1 john.s   | tification Addresses |  |
| Other EFT Contact Not<br>E-mail Address 1 john.s<br>E-mail Address 2                     | tification Addresses |  |
| Other EFT Contact Not<br>E-mail Address 1 john.s<br>E-mail Address 2<br>E-mail Address 3 | tification Addresses |  |

Figure 9 Contact Information and Other EFT Contact Notification Addresses Sections

- 13. In the "Other EFT Contact Notification Addresses" section, add email addresses for any other individuals who should be notified of changes or issues with the EFT account.
- 14. Click Next. The Financial Institution Information page will be displayed.

| Financial Institution Inform     | ation                |              | 9               |
|----------------------------------|----------------------|--------------|-----------------|
| Required fields are indicated w  | ith an asterisk (*). |              |                 |
| • <u>View</u> the EFT user guide | 2.                   |              |                 |
| Search Criteria                  |                      |              |                 |
| ABA Routing Number               |                      |              |                 |
| Financial Institution Name       |                      |              |                 |
|                                  |                      |              | Search <u>*</u> |
|                                  |                      |              |                 |
| Search Results                   |                      |              |                 |
| Financial Institutions           | **                   | _            |                 |
| No rows round                    |                      |              |                 |
| - Selected Einancial Institut    | ion                  |              |                 |
| Selected Financial Institut      | ion                  |              |                 |
| ABA Routing Number               |                      |              |                 |
| Financial Institution Name       |                      |              |                 |
| Address Line 1                   |                      |              |                 |
| Address Line 2                   |                      |              |                 |
| City                             |                      |              |                 |
| State/ZIP                        | -                    |              |                 |
| Telephone Number                 | Ext.                 |              |                 |
| L                                |                      |              |                 |
|                                  | Previous             | <u>N</u> ext | Exit <u>C</u>   |

Figure 10 Financial Institution Information Page

- 15. In the "Search Criteria" section, enter either the ABA routing number or the name of the financial institution you wish to use for settlement of the ForwardHealth EFT payments.
- 16. Click **Search**. A list of the available financial institutions matching your search criteria will be displayed in the "Search Results" section.

| Financial Institution Inform     | ation                |  |  |                    |  | 9      |
|----------------------------------|----------------------|--|--|--------------------|--|--------|
| Required fields are indicated w  | ith an asterisk (*). |  |  |                    |  |        |
| • <u>View</u> the EFT user guide | 3.                   |  |  |                    |  |        |
| Search Criteria                  |                      |  |  |                    |  |        |
| ABA Routing Number               | 070707070            |  |  |                    |  |        |
| Financial Institution Name       |                      |  |  |                    |  |        |
|                                  |                      |  |  |                    | Search *                               |        |
| Search Results                   |                      |  |  |                    |  |        |
| Financial Institutions           |                      |  |  |                    |  |        |
| 070707070 GENERAL BAN            | K GREEN BAY, N.A.    | Address Line 1                         | City<br>GREEN BAY                      | <u>State</u><br>WI | ZIP ZIP+4                              |        |
|                                  | man                  | ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ | ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ | ~~~                | ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ | $\sim$ |

Figure 11 Search Results Section

17. From the displayed list, click the financial institution whose information matches the ABA routing number, name, and address of the institution with which your organization has an account and that your organization wishes to designate as their ForwardHealth EFT financial institution. Information for the selected financial institution will be displayed in the "Selected Financial Institution" section.

| ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ | ~~~~       |             | ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ | ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ | ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ |        |
|---|------------|-------------|---|---|---|--------|
| Celected Financial Ins                  | titution - |             |   |   |   |        |
| ABA Routing Num                         | ber 070    | 707070      |   |   |   |        |
| Financial Institution Na                | me GEN     | ERAL BANK G | REEN BAY, I                             | N.A.                                    |   |        |
| Address Lin                             | e 1        |             |   |   |   |        |
| Address Lin                             | e 2        |             |   |   |   |        |
|   | City GRE   | EN BAY      |   |   |   |        |
| State/                                  | ZIP WI     |             | -                                       |   |   |        |
| Telephone Num                           | ber        |             | Ext.                                    |   |   |        |
|   |            |             |   |   |   |        |
| ι,                                      |            | Previous    | <u>N</u> ext                            |   |   | Exit C |

Figure 12 Selected Financial Institution Section

- 18. Verify that the populated information is correct.
- 19. Click Next. The Account Information page will be displayed.

| Account Information                |                         | ?            |
|------------------------------------|-------------------------|--------------|
| Required fields are indicated with | an asterisk (*).        |              |
| • <u>View</u> the EFT user guide.  |                         |              |
| Account Information                |                         |              |
| Customer Account Number*           | •                       |              |
| Type of Account*                   | Checking C Savings      |              |
| Business or Personal Account*      | * C Business C Personal |              |
| Account Holder Information         |                         |              |
| Name - Account Holder*             |                         |              |
| Street Address Line 1*             |                         |              |
| Street Address Line 2              |                         |              |
| City*                              |                         |              |
| State/ZIP* WI                      | ▼                       |              |
| Telephone Number*                  | Ext.                    |              |
|                                    |                         |              |
|                                    |                         |              |
|                                    | Previous Next Ex        | cit <u>C</u> |

Figure 13 Account Information Page

- 20. Enter information in and select information for the fields in the "Account Information" and "Account Holder Information" sections.
- 21. Click **Next**. The Authorization to Make Electronic Fund Payments page will be displayed.

| <ul> <li>equired fields are indicated with an asterisk (*).</li> <li>Yisy the EFT user guide.</li> <li>Authorization</li> <li>On behalf of the health care provider identified above, by my signature below I hereby represent as follows:</li> <li>I authorize the Department of Health Services (DHS) to deposit, by electronic funds transfer, payments owed to the provider by the State of Wisconsin and, if necessary, initiate debit adjustments for any electronic deposits made in error to the account indicated above. I hereby authorize the financial institution/bank named above to credit and/or debit the same to such account.</li> <li>I acknowledge that if thus deposited pursuant to this authorization are payments by the State of Wisconsin and are subject to the same laws, rules and policies as payments made in any other maner.</li> <li>I acknowledge that if the provider falls to provide complete and accurate information DHS deposits payments into an account over which the provider does not have control, I agree that DHS shall be held hermises for such payments.</li> <li>I hereby certify that the provider has control of the account referenced above, and that the financial institution and attra arangements between the financial institution and the provider are in compliance with all applicable federal and Automated Clearing House (ACH) regulations and instructions.</li> <li>I acknowledge that any information provided in this document constitutes a statement or representation of a material fact Knowledge that this authorization is effective as of the signature date below and will remain in full force and effect until the DHS has received written notification from an authorized representative of provider at least thirty (30) days in advance of its termination. The DHS will continue to send the direct deposit to the financial institution indicated above, provider are in addition to any and all other requirements and obligations entities to representations on provider's behalf contained herein.</li> <li>I acknowledge that th</li></ul> | <ul> <li>pured fields are indicated with an asterisk (*).</li> <li>y ying: the EFT user guide.</li> <li>Authorization</li> <li>On behalf of the health care provider identified above, by my signature below I hereby represent as follows:</li> <li>1. authorize the Department of Health Services (DHS) to deposit, by electronic funds transfer, payments oved to the provider by the State of Wisconsin and, if necessary, initiate debit adjustments for any electronic deposits made in error to the account indicated above. I hereby authorize the financial institution/bark named above to credit and/or debit the same to such account.</li> <li>1. authorizes the Department of Health Services (DHS) to deposit, by electronic funds transfer, payments over and are subject to the same laws, rules and policies as payments made in any other manner.</li> <li>1. acknowledge that the vervet that due to failure to provide complete and accurate information DHS deposits payments into an account over which the provider does not have control, I agree that DHS shall be held hamess for such payments.</li> <li>1. J acknowledge that the provider has control of the account referenced above, and that the financial institution and the provider are in compliance with all applicable federal and Automated Clearing House (ACH) regulations and instructions.</li> <li>1. J acknowledge that the subtorization is offictive as of the signature date below and will remain in full force and effect until the DHS has received written notification from an authorized representation of a material fact knowingly and willfully made or caused to be made for use in determining rights to payment within the maning of its termination. The DHS will continue to so and the regulations contained herein are in addition receiving the direct deposit. If provider's EFT information changes, provider agrees to submit to the DHS an updated EFT Authorized Agerter.</li> <li>1. acknowledge that the requirements and obligations contained herein are in addition roa yn and alor therefare ano</li></ul>   | thorization to Make  | Electronic Fund Payments   | ? |
|--|--|--|--|---|
| Year the EFT user guide.      Authorization      Monoration      Monoratin      Monoration      Monoration      Monoratin      Monoratin                 | Yinter the FFT user guide.          Authorization         Default of the health care provider identified above, by my signature below 1 hereby represent as follows:         1. authorize the Department of Health Services (DHS) to deposit, by electronic funds transfer, payments oved on the provider by the State of Wisconsin and, if necessary, initiate debit adjustments for any electronic and a provider by the State of Wisconsin and, if necessary, initiate debit adjustments for any electronic and are subject to the same laws, rules and policies as payments made in enry other manner.         1. Jourdowledge that the vervet that due to failure to provide complete and accurate information on this authorization form, the processing of the form may be delayed or my payments may be erroneously transferred eleval and automated Clearing House (ACH) regulations and instructions.         1. Is reby certify that the provider has control of the account referenced above, and that financial institution and all armagements between the financial institution and the provider are in compliance of \$4.99.4(1) and (4m), Wis. Stats., and that if any such information in full force any payments in the maning of \$4.99.4(1) and (4m), Wis. Stats., and that if any such information in falles, crimal for the sa ubtorization form an authorized representative of provider this authorization is effective and duction received wither motification from an authorized representative of provider this transfer in compliance and bus in advance of its termination. The DHS will continue to and the deposit to the francial institution receiving the direct daposet under the information in applicable provider that provider has contrained herein are in addition receiving and the francial institution receiving the direct daposet to the francial institution receives and the direct daposet to the provider has doposits paymentis and ob  | uired fields are indic   | ated with an asterisk (*).   |   |
| Authorization         On behalf of the health care provider identified above, by my signature below I hereby represent as follows:         1. I authorize the Department of Health Services (DHS) to deposit, by electronic funds transfer, payments owed to the provide by the State of Wisconsin and, if necessary, initiate debit adjustments for any electronic deposits made in error to the account indicated above. I hereby authorize the financial institution/Dank are subject to the same laws, rules and policies as payments mode in any other mancial institution/Dank are subject to the same laws, rules and policies as payments mode in any other mancial institution/Dank are subject to the same laws, rules and policies as payments mode in any other mancial on this authorization form, the processing of the form may be delayed or my payments must be erroneously transferred electronically. In the event that due to failure to provide complete or accurate information DHS deposits payments into an account over which the provider has control of the account referenced above, and that the financial institution and all arrangements between the financial institution and the provider are in compliance with all applicable federal and Automated Clearing House (ACH) regulations and instructions.         5. I acknowledge that any information provided in this document constitutes a statement or representation of a material fact knowing of s.49.49(1) and (4m), Wis. Stats., and that if any such information follays in advance of its termination. The DHS will continue to send the direct deposit to the financial institution indicated above until notified in accordance with this paragraph by an authorized representative of provider state provider has contained herein are in demining rights to payment and a fifter tuntil the DHS has received witten notification from an authorized negresentative of provider ta lease the requirements and ob  | Authorization         On behavior       1 authorize the Department of Health Services (DHS) to deposit, by electronic funds transfer, payments owed deposits made in error to the account indicated above. I hereby authorize the financial institution/bank and above to credit and/or debit the same laws, rules and policies as payments by the State of Wisconsin and, if necessary, initiate debit adjustments for any electronic form are subject to the same laws, rules and policies as payments made in any other manner.         1. Jacknowledge that funds deposited pursuant to this authorization are payments by the State of Wisconsin and, the provider fails to provide complete and accurate information on this authorization form, the processing of the form may be delayed or my payments may be enroneously transferred electronically. In the event that due to failure to provide romelts or accurate information on this authorization for such payments.         2. I checky certify that the provider has control of the account referenced above, and that the financial institution and all arrangements between the financial institution and the provider are in compliance with all applicable federal and Automated Clearing House (ACH) regulations and instructions.         2. I acknowledge that this authorization is effective as of the signature date below and will remain in full force an other paralities may be imposed under those laws.         3. I acknowledge that the requirements and beignation contained herein are in addition to any and all arrangements between to thication from an authorized representative of provider at the provider wishes to change the financial institution receiving the direct deposit to the financial institution indicated above until notification from an authorized representative of provider that provide wishes to change the financial institution   | • View the EFT use   | r guide.   |   |
| Authorization On behalf of the health care provider identified above, by my signature below 1 hereby represent as follows: 1. I authorize the Department of Health Services (DHS) to deposit, by electronic funds transfer, payments owed to deposits made in error to the account indicated above. I hereby authorize the financial institution/bank named above to credit and/or debit the same to such account. 2. I acknowledge that funds deposited pursuant to this authorization are payments by the State of Wisconsin and are subject to the same laws, rules and policies as payments made in any other manner. 3. I acknowledge that funds deposited pursuant to this authorization of this authorization form, the processing of the form may be delayed or my payments may be erroneously transferred electronically. In the event that due to failure to provide complete and accurate information on this authorization form, the processing of the form may be delayed or my payments may be erroneously transferred electronically. In the event that due to failure to provide complete and accurate information DHS deposits payments into an account over which the provider does not have control, I agree that DHS shall be held hamplicable federal and Automated Clearing House (ACH) regulations and instructions. 3. I aknowledge that any information provided in this document constitutes a statement or representation of a material fact knowingly and willfully made or caused to be made for use in determining rights to payment within the meaning of s.49.49(1) and (4m). Wis. Stats., and that if any such information in full force and effect until the DHS has received written notification form an authorized representative of provider at the provider wishes to change the financial institution and the direct deposit to the financial institution indicated above until notified in account even with the preavide mation indicated above until notified in account and any information shaltes the received written notification form a   | Authorizetion         On behalf of the health care provider identified above, by my signature below I hereby represent as follows:         1. J authorize the Department of Health Services (DHS) to deposit, by electronic funds transfer, payments owed deposits made in error to the account indicated above. I hereby authorize the financial institution/bank named above to credit and/or debit the same laws, rules and policies as payments may the state of Wisconsin and are subject to the same laws, rules and policies as payments may the may to the State of Wisconsin on this authorization are payments by the State of Wisconsin of the provider fails to provide complete and accurate information on this authorization form, the processing of the form may be delayed or my payments may be enroneously transferred electronically. In the event that due to failure to provide complete or accurate information on this authorization for may be delayed or my payments may be are in compliance with all applicable faderal and Automated Clearing House (ACH) regulations and instructions.         9. I acknowledge that any information provided in this document constitutes a statement or representation of a maple inpact of the form where the state, and that if any such information is false, criminal or other paralise may be imposed under those laws.         1. I acknowledge that this authorization is effective as of the signature date below and will remain in full force and effect until the DHS are received written notification from an authorized representative of provider at least thirty (30) days in advance of its termination. The DHS will continue to send the direct deposit to the financial institution indicated above until intification form an authorized persentative of provider at least thirty (30) days in advance of its termination.         1. J acknowledge that the requirement  |  |  |   |
| <ul> <li>On behalf of the health care provider identified above, by my signature below I hereby represent as follows:</li> <li>I authorize the Department of Health Services (DHS) to deposit, by electronic funds transfer, payments owed to the provider by the State of Wisconsin and, if necessary, initiate debit adjustments for any electronic deposits made in error to the account indicated above. I hereby authorize the financial institution/bank named above to credit and/or debit the same to such account.</li> <li>I acknowledge that funds deposited pursuant to this authorization are payments by the State of Wisconsin and are subject to the same laws, rules and policies as payments made in any other manner.</li> <li>I acknowledge that if the provider fails to provide complete and accurate information on this authorization form, the processing of the form may be delayed or my payments may be ernocusly transferred electronically. In the event that due to failure to provide complete or accurate information DHS deposits payments into an account over which the provider does not have control, I agree that DHS shall be held harmess for such payments.</li> <li>I hereby certify that the provider has control of the account referenced above, and that the financial institution and all arrangements between the financial institution and instructions.</li> <li>I acknowledge that any information provided in this document constitutes a statement or representation of a material fact knowingly and willfully made or caused to be made for use in determining rights to payment within the meaning of s.49.49(1) and (4m), Wis. Stats., and that if any such information is false, criminal or other penalties may be inposed under those laws.</li> <li>I acknowledge that this provider wishes to change the financial institution receiving withen toffied in accordance with this paragraph by a authorized representative of provider that provider wishes to change the financial institution receiving the direct deposit to the f</li></ul>                             | <ul> <li>On behalf of the health care provider identified above, by my signature below 1 hereby represent as follows:</li> <li>I authorize the Department of Health Services (DHS) to deposit, by electronic funds transfer, payments owed to the provider by the State of Wisconsin and, if necessary, initiate debit adjustments for any electronic deposits made in error to the account indicated above. I hereby authorize the financial institution/bank named above to credit and/or debit the same to such account.</li> <li>I acknowledge that funds deposited pursuant to this authorization are payments by the State of Wisconsin and are subject to the same laws, rules and policies as payments made in any other manner.</li> <li>I acknowledge that if the provider fails to provide complete and accurate information on this authorization form, the processing of the form may be delayed or my payments may be erroneously transferred electronically. In the event that due to failure to provide complete and accurate information DHS deposits payments into an account over which the provider does not have control, I agree that DHS shall be held harmless for such payments.</li> <li>I acknowledge that any information provided in this document constitutes a statement or representation of a material fact knowingly and willfully made or caused to be made for use in determining rights to payment within the meaning of s.49.49(1) and (4m). Wis. Stats., and that if any such information is false, criminal or other panalities may be imposed under those laws.</li> <li>I acknowledge that this authorization is effective as of the signature date below and will remain in full force and effect until the DHS has received written notification from an authorized representative of provider at least thirty (30) days in advance of its termination. The DHS will continue to send the direct deposit. If provider SET information changes, provider agrees to submit to the DHS an ucpotate ETT authorization Agreement.</li> <li>I acknowledge th</li></ul>   | Authorization  |  |   |
| <ul> <li>I authorize the Department of Health Services (DHS) to deposit, by electronic funds transfer, payments owed to the provider by the State of Wisconsin and, if necessary, initiate debit adjustments for any electronic deposits made in error to the account indicated above. I hereby authorize the financial institution/bank named above to credit and/or debit the same to such account.</li> <li>I acknowledge that finds deposited pursuant to this authorization are payments by the State of Wisconsin and are subject to the same laws, rules and policies as payments made in any other manner.</li> <li>I acknowledge that if the provider fails to provide complete and accurate information on this authorization form, the processing of the form may be delayed or my payments may be erroneously transferred electronically. In the event that due to failure to provide complete or accurate information DHS deposits payments into an account over which the provider does not have control, I agree that DHS shall be held hamless for such payments.</li> <li>I acknowledge that any information provided in this document constitutes a statement or representation of a material fact knowingly and willfully made or caused to be made for use in determining rights to payment within the meaning of s.49.49(1) and (4m). Wis: Stats., and that if any such information is false, crimial or other penalties may be imposed under those laws.</li> <li>I acknowledge that this authorization is effective as of the signature date below and will remain in full force and effect until the DHS has received written notification from an authorized representative of provider the spresentative of provider that provider wises to change the financial institution receiving the direct deposit. If provider's EFT information changes, provider agrees to submit to the DHS and update EFT Authorization sequirements and obligations sont provider hard belagations set forth in federal and state statutes and rules and applicable provider handbooks and updates.</li></ul>                     | <ol> <li>I authorize the Department of Health Services (DHS) to deposit, by electronic funds transfer, payments owed to the provider by the State of Wisconsin and, if necessary, initiate debit adjustments for any electronic deposits made in error to the account indicated above. I hereby authorize the financial institution/bank named above to credit and/or debit the same to such account.</li> <li>I acknowledge that funds deposited pursuant to this authorization are payments by the State of Wisconsin and are subject to the same laws, rules and policies as payments made in any other manner.</li> <li>I acknowledge that if the provider fails to provide complete and accurate information on this authorization form, the processing of the form may be delayed or my payments may be erroneously transferred electronically. In the event that due to failure to provide rome to have control, I agree that DHS shall be held harmless for such payments.</li> <li>I hereby certify that the provider has control of the account referenced above, and that the financial institution and all arrangements between the financial institution and instructions.</li> <li>I acknowledge that any information provided in this document constitutes a statement or representation of a material fact knowingly and willfully made or caused to be made for use in determining rights to payment within the meaning of s.49.49(1) and (4m), Wis. Stats., and that if any such information if alse, criminal or other penalties may be imposed under those laws.</li> <li>I acknowledge that this authorization is effective as of the signature date below and will remain in full force and effect until the DHS has received written notification from an authorized representative of provider ta least thirty (30) days in advance of its termination. The DHS will contained hereit deposit to the financial institution receiving the direct deposit. If provider's EFT information changes, provider agrees to submit to the DHS an updated EFT Authorization Agreement.<!--</td--><td>On behalf of the h</td><th>ealth care provider identified above, by my signature below I hereby represent as follows:</th><td></td></li></ol> | On behalf of the h   | ealth care provider identified above, by my signature below I hereby represent as follows:   |   |
|  |  | <ol> <li>I authorize ti<br/>to the provid<br/>deposits manamed abov</li> <li>I acknowled<br/>form, the prelectronicall<br/>payments in<br/>harmless for</li> <li>I acknowled<br/>form, the prelectronicall<br/>payments in<br/>harmless for</li> <li>I hereby cerinstitution a<br/>applicable fe</li> <li>I acknowled<br/>material fact<br/>within the mother penaltic<br/>contained the<br/>other penaltic<br/>lacknowled<br/>and effect un<br/>least thirty if<br/>financial insti<br/>representati<br/>deposit. If p<br/>Authorizatio</li> <li>I acknowled<br/>requirements<br/>that is part<br/>and state st</li> <li>I am an auth<br/>contained here</li> </ol> | he Department of Health Services (DHS) to deposit, by electronic funds transfer, payments owed der by the State of Wisconsin and, if necessary, initiate debit adjustments for any electronic de in error to the account indicated above. I hereby authorize the financial institution/bank e to credit and/or debit the same to such account.<br>ge that funds deposited pursuant to this authorization are payments by the State of Wisconsin ect to the same laws, rules and policies as payments may be more on this authorization occessing of the form may be delayed or my payments may be erroneously transferred y. In the event that due to failure to provide complete and accurate information DHS deposits to an account over which the provider does not have control, I agree that DHS shall be held such payments.<br>tify that the provider has control of the account referenced above, and that the financial nd all arrangements between the financial institution and the provider are in compliance with all deral and Automated Clearing House (ACH) regulations and instructions.<br>ge that any information provided in this document constitutes a statement or representation of a texaming of s.49.49(1) and (4m), Wis. Stats., and that if any such information is false, criminal or ise may be imposed under those laws.<br>and the financial institution from an authorized representative of provider at (30) days in advance of its termination. The DHS will continue to send the direct deposit to the itution indicated above until motified in accordance with this paragraph by an authorized ve of provider that provider wishes to change the financial institution receiving the direct rovider's ETT information changes, provider and councies and obligations set forth in federal atutes and rules and applicable provider handbooks and updates.<br>forward representative of the provider with power to make all representations on provider's behalf are in accide representative of the provider shall be requirements and obligations provider and updates.<br>Torized representa |   |

Figure 14 Authorization to Make Electronic Fund Payments Page

- 22. Read the Authorization statement.
- 23. Check the box next to "I Agree to the statements above."
- 24. Enter your signature, title, and the date.

Note: This is a legally binding agreement. If you do not agree to these statements, you will not be enrolled in EFT.

25. Click **Next**. The Summary page will be displayed.



Figure 15 Summary Page

26. To preview your request, click **Preview EFT Request**. A draft PDF version of your EFT request(s) will be displayed in a separate window. Each agreement consists of two pages. (Multiple EFT requests will be displayed in one PDF.)

| EPARTMENT OF HEALTH SERVICES<br>vision of Health Care Access and Accountability<br>-13488 (05/09)   |                 |                            |                     | STATE C             | FWISCONSIN         | DIRECT DEPOSIT AUTHORIZATION FOR ELECTRONIC<br>F-13468 (0200)   | INENT OF HEALTH SERVICES SDIECT CEROSIT AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER (FT) REQUEST ( Finde Carlos and Accountability (1050) SECTION VII — AUTHORIZATION TO MAKE ELECTRONIC FUND PAYMENTS   |   |  |  |  |  |  |  |  |
|---|-----------------|----------------------------|---------------------|---------------------|--------------------|---|--|---|--|--|--|--|--|--|--|
|   | FORWARDH        | EALTH                      |                     |                     |                    | SECTION VII — AUTHORIZATION TO MAKE EL<br>On behalf of the health care provider identified abo  | ECTRONIC FUND PAYMENTS<br>type, by my signature below I hereby represent as follows:   |   |  |  |  |  |  |  |  |
| DIRECT DEPOSIT AUTHORIZATION F(<br>istruotions: Type or print clearly. Before completing thi<br>JFT) Request Completion Instructions, F-13468A. | S form, read th | RONIC FU                   | INDS TRANS          | FER (EFT) RE        | EQUEST<br>Transfer | <ol> <li>I authorize the Department of Health Services (i<br/>State of Wisconsin and, if necessary, initiate debit<br/>above. I hereby authorize the financial institution/b</li> </ol> | DHS) to deposit, by electronic funds transfer, payments owe<br>adjustments for any electronic deposits made in error to the<br>ank named above to credit and/or debit the same to such ac  | d to the provider by the<br>account indicated<br>count. |  |  |  |  |  |  |  |
| ECTION I REASON FOR REQUEST   |                 |                            |                     |                     |                    | <ol><li>I acknowledge that funds deposited pursuant to<br/>same laws, rules and policies as payments made i</li></ol>   | this authorization are payments by the State of Wisconsin a<br>in any other manner.  | nd are subject to the                                   |  |  |  |  |  |  |  |
| EFT Termination Request   |                 |                            |                     |                     |                    | <ol> <li>I acknowledge that if the provider fails to provide<br/>the form may be delayed or my payments may be</li> </ol>   | ecomplete and accurate information on this authorization for<br>erroneously transferred electronically. In the event that due  | m, the processing of<br>to failure to provide           |  |  |  |  |  |  |  |
| ECTION II - PROVIDER LOCATIONS / CERTIFICAT   | IONS IMPACT     | TED                        |                     |                     |                    | complete or accurate information DHS deposits pa<br>DHS shall be held barmless for such payments  | syments into an account over which the provider does not ha  | ve control, I agree that                                |  |  |  |  |  |  |  |
| or Health Care Providers  | <u> </u>        |                            | -                   | Paver               |                    |   |  |   |  |  |  |  |  |  |  |
| NPI* or Name Address City   | State           | ZIP Code                   | Code                | (MA, WWWP,<br>WCDP) | SSN or<br>EIN      | <ol> <li>I hereby certify that the provider has control of t<br/>arrangements between the financial institution and<br/>House (ACH) regulations and instructions.</li> </ol>            | the account referenced above, and that the financial institution<br>the provider are in compliance with all applicable federal and<br>the provider are in compliance with all applicable federal and the provider and th | n and all<br>d Automated Clearing                       |  |  |  |  |  |  |  |
| 0000001   |                 | 3818                       | 100000000           | MA                  | 123450789          | 5 Lacknowledge that any information provided in   | this document constitutes a statement or representation of a   | material fact   |  |  |  |  |  |  |  |
|   |                 |                            |                     |                     |                    | knowingly and wilfully made or caused to be made<br>(4m). Wis State, and that if any such information   | I for use in determining rights to payment within the meaning<br>is faise criminal or other penalties may be imposed under th  | of s.49.49(1) and<br>ose laws.                          |  |  |  |  |  |  |  |
| A National Provider Identifier (NPI) is required for all h<br>Provider ID.  | ealth care pro  | viders. Non-he             | althcare providers  | may enter their M   | edicaid            | <ol> <li>I acknowledge that this authorization is effective<br/>DUE has received written politication.</li> </ol>   | e as of the signature date below and will remain in full force a   | and effect until the                                    |  |  |  |  |  |  |  |
| ECTION III - PAY TO ADDRESS ON FILE FOR LOC   | ATIONS / CEP    | RTIFICATIONS               | LISTED ABOVE        | (Must Be the Sam    | e Address for      | termination. The DHS will continue to send the dire   | ect deposit to the financial institution indicated above until no  | tified in accordance                                    |  |  |  |  |  |  |  |
| ( Locations)  |                 |                            |                     |                     |                    | with this paragraph by an authorized representativ<br>direct deposit. If provider's EET information change  | e of provider that provider wishes to change the financial ins   | titution receiving the                                  |  |  |  |  |  |  |  |
| arre — Business or Individual   |                 |                            |                     |                     |                    | Agreement.  |  |   |  |  |  |  |  |  |  |
| ddress — Business or Individual (Street, City, State, Zif   | Code)           |                            |                     |                     |                    | 7. Lacknowledge that the requirements and obliga  | tions contained herein are in addition to any and all other re   | ouirements and  |  |  |  |  |  |  |  |
| OD NELSON AVE PLATTEVILLE, M  | 153818          |                            |                     |                     |                    | obligations applicable to provider in connection wit  | h provider's participation in any program that is part of Forw   | ardHealth, including                                    |  |  |  |  |  |  |  |
| ECTION IV - CONTACT INFORMATION FOR EFT N   | OTIFICATION     |                            |                     |                     |                    | and updates.  | form in rederal and state statutes and rules and applicable p  | rovider nandbooks                                       |  |  |  |  |  |  |  |
| ame — Contact Person  |                 | E-mail Addr                | ess — Contact Per   | son                 |                    |   |  |   |  |  |  |  |  |  |  |
| JANE DOE  |                 | jane.do                    | e@abc.com           |                     |                    | <ol> <li>Tam an authorized representative or the provid</li> </ol>  | er with power to make all representations on provider's bena   | r contained herein.                                     |  |  |  |  |  |  |  |
| elephone Number — Contact Person  |                 | Fax Number                 | r — Contact Perso   | n                   |                    | SIGNATURE - Authorized Agent  | Name — Authorized Agent (Printed)  |   |  |  |  |  |  |  |  |
| (920) 123-4567 Ext. 111   | 1               | (608) 11                   | 1-2345              |                     |                    | Jane Doe  |  |   |  |  |  |  |  |  |  |
| ECTION V - FINANCIAL INSTITUTION INFORMATIO   | N               |                            |                     |                     |                    | Title   | Date Signed  |   |  |  |  |  |  |  |  |
| ame — Financial Institution   |                 |                            |                     |                     |                    | Finance Director  | 07/28/2011   |   |  |  |  |  |  |  |  |
| ENERAL BANK GREEN BAY, N.A.   |                 |                            |                     |                     |                    | SIGNATURE — Authorized Agent (optional)   | Name — Authorized Agent (Printed)  |   |  |  |  |  |  |  |  |
| ddress — Financial Institution (Street, City, State, ZIP C<br>GREEN BAY, WI   | ode) T)         | ype of Account<br>Checking |                     | Business or Pers    | onal Account:      |   |  |   |  |  |  |  |  |  |  |
| GREEN BAT, WI   |                 | Other (spect               | N):                 | Personal            |                    | Title   | Date Signed  |   |  |  |  |  |  |  |  |
| ontact Name — Financial Institution   | Te              | elephone Num               | ber — Financial Ins | atution             |                    |   |  |   |  |  |  |  |  |  |  |
| BA Routing Number (Nine Digit)  | Ci              | ustomer Accou              | int Number          |                     |                    |   |  |   |  |  |  |  |  |  |  |
| 1 7 5 9 0 0 5 7 5   |                 | 123456789                  | 12111213            |                     |                    | Internal Use Only<br>Aurit - Liser Name   | Aurit - Liser ID   |   |  |  |  |  |  |  |  |
| ECTION VI - ACCOUNT HOLDER INFORMATION  | ( )             |                            |                     |                     |                    |   |  |   |  |  |  |  |  |  |  |
| ame — Account Holder  |                 | Telephone                  | Number — Accour     | nt Holder           |                    | Test Provider   | PROV1UAT   |   |  |  |  |  |  |  |  |
| MIN CHARGE  |                 | (608) 55                   | 55-1212 Ext. 1      |                     |                    | Auss - Daterrime  |  |   |  |  |  |  |  |  |  |
| ddress — Account Holder (Street, City, State, ZIP Code  | :)              |                            |                     |                     | _                  | Thursday, July 28, 2011 9:29:11 AM  |  |   |  |  |  |  |  |  |  |
| 123 VP LANE, MADISON, WI 53719-1234   | ŧ.              |                            |                     |                     |                    |   |  |   |  |  |  |  |  |  |  |
|   |                 |                            |                     |                     | Continued          |   |  | ET_   |  |  |  |  |  |  |  |
|   |                 |                            | -01                 |                     | -                  |   | -DRF   |   |  |  |  |  |  |  |  |

Figure 16 Draft PDF Version of EFT Request

Note: Do *not* print and fax or mail these requests to ForwardHealth. ForwardHealth does not accept paper enrollments. The enrollment will be submitted when you click Submit on the Summary page.

27. Verify that the information displayed in the draft PDF version is accurate.

To make changes to an EFT request, click **Previous** until you return to the appropriate page. Change the necessary information.

28. Click **Submit** on the Summary page to submit the EFT enrollment request(s). The EFT Request was Submitted page will be displayed.



Figure 17 EFT Request Was Submitted Page

The EFT Request was Submitted page confirms that your EFT request(s) was submitted successfully and describes next steps.

- 29. To save a copy of your EFT request(s) for your records, click **Save**. A draft PDF version of your EFT request(s) will be displayed in a separate window.
- 30. Click **Exit**. You will be redirected to the secure Provider page.

# **3** Check the Status of your Electronic Funds Transfer Enrollment

### **3.1 Access Electronic Funds Transfer Enrollment Status** Information

- 1. Access the ForwardHealth Portal at <a href="https://www.forwardhealth.wi.gov/">https://www.forwardhealth.wi.gov/</a>.
- 2. Log in to your secure Provider Portal account.
- 3. Click Electronic Funds Transfer located in the Home Page box on the right of the page.

| S wisconsin.gov home state agencies subject directory department of health services  |   |  |  |  |
|--|---|--|--|--|
| ForwardHealth<br>Wisconsin serving you Provider  | Welcome Inpatient03 UAT > May 7, 2019 2:35 PM   |  |  |  |
| Home         Search         Providers         Enrollment         Claims         Prior Authorization         Remittance Advices         Trade Files           Account         Contact Information         Online Handbooks         Site Map         User Guides         Certification   | Health Check Max Fee Home   |  |  |  |
| You are logged in with NPI: 1255334173, Taxonomy Number: 282N00000X, Zip Code: 53226, Financial<br>Payer: Medicaid<br>Providers  | Search Search   |  |  |  |
| Providers can improve efficiency while reducing overhead and paperwork by using real-time applications available on the new ForwardHealth Portal. Submission and tracking of claims and prior authorization requests and amendments, on-demand access to remittance information, 835 trading partner designation, and instant access to the most current ForwardHealth information is now available. | Update User Account     Customize Home Page     Demographic Maintenance     Electronic Funds Transfer     Check My Revalidation Date     Revalidate Your Provider Enrollment     Check Enrollment |  |  |  |
| New Rate Reform Part 3 Ideas/Recommendations Requested.  |   |  |  |  |
| Incentive Payments Are you Eligible?   |   |  |  |  |
| ForwardHealth System Generated Claim Adjustments   | Quick Links     Register for E-mail Subscription  |  |  |  |

Figure 18 Electronic Funds Transfer Link

The Introduction page will be displayed.

| Introduction  |
|---|
| Required fields are indicated with an asterisk (*).   |
| For New EFT enrollments or Changes to Existing EFT Enrollments:   |
| You will need to have the following information available:  |
| <ul> <li>The name and email address for the person in your organization that will serve as the contact for all<br/>EFT information.</li> </ul>  |
| <ul> <li>The financial institution's ABA routing number.</li> <li>The account number and the name on record with the bank/financial institution as the Account Holder for the account.</li> </ul> |
| <ul> <li>The type of account (savings or checking, personal or business).</li> </ul>  |
| Existing EFT Data   |
| <ul> <li>Any existing EFT information will be pre-populated based on the current organization you are logged<br/>in with.</li> </ul>  |
| To Check the Status of Your EFT Enrollment:   |
| Click "Next" below and a status screen will appear.   |
| User Guide  |
| • <u>View</u> the EFT user guide.   |
| EFT Processing Overview   |
| <u>View</u> the EFT processing overview.  |
|   |
| Next Exit C   |

Figure 19 Introduction Page

4. Click **Next**. The Electronic Funds Transfer Request page will be displayed.

| Organization  | i List        |       |       |       |            |                 |                           |                |            |              |            |
|---------------|---------------|-------|-------|-------|------------|-----------------|---------------------------|----------------|------------|--------------|------------|
| Organizatio   | n List        |       |       |       |            |                 |                           |                |            |              |            |
| Provider ID   | City          | State | ZIP   | ZIP+4 | Taxonomy   | Provider Type   | Payer                     | EFT Status     | Add/Change |              |            |
| 0000000001    | LADYSMITH     | WÍ    | 54848 |       | 000N00000X | Physician Group | Medicaid                  | No EFT on file |            | View History |            |
| 0000000002    | PLATTEVILLE   | WI    | 53818 | 1264  | 100N00000X | Hospital        | Medicaid                  | No EFT on file |            | View History |            |
| 0000000003    | COTTAGE GROVE | WI    | 53527 |       | 200N00000X | Pharmacy        | Medicaid                  | Active         |            | View History |            |
| 000000004     | MIDDLETON     | WI    | 53562 |       | 300N00000X | Dentist         | Medicaid                  | Active         |            | View History |            |
| 000000005     | LADYSMITH     | WI    | 54848 |       | 400N00000X | Physician Group | Medicaid                  | No EFT on file |            | View History |            |
| 0000000006    | GREEN BAY     | WI    | 54305 |       | 500N00000X | Hospital        | Wisconsin Chronic Disease | No EFT on file |            | View History |            |
|               |               |       |       |       |            |                 |                           |                |            | _            | Select All |
|               |               |       |       |       |            |                 |                           |                |            |              |            |
| luait History | /             |       |       |       |            |                 |                           |                |            |              |            |
|               |               |       |       |       |            |                 |                           |                |            |              |            |

Figure 20 Electronic Funds Transfer Request Page

If you are an EFT clerk, this page will display all the service locations for which you are assigned the EFT role. Account administrators will see all of the service locations for the provider under which they are logged in.

The EFT Status column displays the current status of each service location.

#### **3.1.1 Enrollment Statuses**

#### Pending

A *Pending* status indicates that ForwardHealth is preparing to initiate the required prenotification test transaction with the financial institution designated as your organization's ForwardHealth EFT settlement account.

#### Prenotification

A *Prenotification* status indicates that ForwardHealth has initiated the prenotification test transaction with the designated financial institution and is awaiting a response. Prenotification testing can take up to 15 banking days to complete. A *Prenotification* status also indicates that ForwardHealth has not received notification of any error in the EFT account set-up from the financial institution during the testing process to date.

#### Active

An *Active* status indicates that the required prenotification testing process has been completed without error. The next scheduled payment will be made by EFT and the payments directly deposited into the provider's EFT settlement account at the designated financial institution.

The EFT enrollment will remain in an *Active* status unless you change your enrollment information or the financial institution initiates a change in their ABA routing number or settlement account information.

#### Failed

A *Failed* status indicates that errors occurred during the required prenotification test process with the designated financial institution. If this occurs, ForwardHealth will work with the provider's financial institution to resolve the errors and generate a second prenotification test with the financial institution. When necessary, ForwardHealth will contact the EFT contact person identified on the EFT enrollment form for your organization to verify or correct information.

#### Interrupt

An *Interrupt* status is a temporary status that forces a paper check to be issued. Electronic funds transfers will only be placed in this status at the direction of ForwardHealth. The EFT account remains valid while the account is in an *Interrupt* status and can be placed back into an *Active* status to resume scheduling EFTs.

#### No EFT on File

A *No EFT on file* status indicates that an EFT request has not been submitted for a specific service location or that an EFT request has been canceled.

## **3.2 View History**

To view the enrollment history for a specific service location, click **View History** next to the specific service location. The "Audit History" section will populate with any changes made to the EFT enrollment for the selected service location.

| electronic Fund  | s Transfer Requ    | est     |                    |                       |                               |                  |                           |                |            |              |
|--|--------------------|---------|--------------------|-----------------------|-------------------------------|------------------|---------------------------|----------------|------------|--------------|
| equired fields are   | e indicated with a | an aste | erisk (*           | ).                    |                               |                  |                           |                |            |              |
|  |                    |         |                    |                       |                               |                  |                           |                |            |              |
| <u>View</u> the El   | FT user guide.     |         |                    |                       |                               |                  |                           |                |            |              |
| Select the   | organization(s) t  | hat yo  | u want             | to add/o              | change the E                  | FT information.  |                           |                |            |              |
| <ul> <li>Organizatio</li> <li>To view the</li> </ul>   | e audit history of | an or   | a penu<br>Janizati | ng statu<br>on, seler | is can not be<br>nt the "View | History" button  | from the list below.      |                |            |              |
| • TO VIEW CIT  | e addre miscory of |         | Janizaci           | on, selev             | st the view                   | inscory buccon   | from the list below.      |                |            |              |
| - Organization   | List               |         |                    |                       |                               |                  |                           |                |            |              |
| Organizatio  | n List             |         |                    |                       |                               |                  |                           |                |            |              |
| Provider ID  | City               | State   | ZIP                | ZIP+4                 | Taxonomy                      | Provider Type    | Payer                     | EFT Status     | Add/Change |              |
| 000000001  | LADYSMITH          | WI      | 54848              |                       | 000N00000X                    | Physician Group  | Medicaid                  | No EFT on file |            | View History |
| 000000002  | PLATTEVILLE        | WI      | 53818              | 1264                  | 100N00000X                    | Hospital         | Medicaid                  | No EFT on file |            | View History |
| 000000003  | COTTAGE GROVE      | WI      | 53527              |                       | 200N00000X                    | Pharmacy         | Medicaid                  | Active         |            | View History |
| 000000004  | MIDDLETON          | WI      | 53562              |                       | 300N00000X                    | Dentist          | Medicaid                  | Active         |            | View History |
| 000000005  | LADYSMITH          | WI      | 54848              |                       | 400N00000X                    | Physician Group  | Medicaid                  | No EFT on file |            | View History |
| 000000006  | GREEN BAY          | WI      | 54305              |                       | 500N00000X                    | Hospital         | Wisconsin Chronic Disease | No EFT on file |            | View History |
|  |                    |         |                    |                       |                               |                  |                           |                |            | Select All M |
|  |                    |         |                    |                       |                               |                  |                           |                |            |              |
|  |                    |         |                    |                       |                               |                  |                           |                |            |              |
| - Audit History  | /                  |         |                    |                       |                               |                  |                           |                |            |              |
| Audit Nictor   |                    |         |                    |                       |                               |                  |                           |                |            |              |
| Date   | Action             | _       | _                  | Desc                  | ription of Actio              | n                |                           |                |            |              |
| 07/28/2011 Business/Personal account indicator Business/Personal account indicator changed from Personal to Business |                    |         |                    |                       |                               |                  |                           |                |            |              |
|  |                    |         |                    |                       |                               |                  |                           |                |            |              |
|  |                    |         |                    |                       |                               |                  |                           |                |            |              |
|  |                    |         |                    |                       |                               |                  |                           |                |            |              |
|  |                    |         |                    |                       | Previo                        | ous <u>N</u> ext |                           |                |            | Exit C       |

Figure 21 Electronic Funds Transfer Request Page

# 4 Update Information on an Active Electronic Funds Transfer

In order to change information for an EFT enrollment, the enrollment must be in an *Active* status. To update or change information for an active EFT enrollment, complete the following steps:

- 1. Access the ForwardHealth Portal at <a href="https://www.forwardhealth.wi.gov/">https://www.forwardhealth.wi.gov/</a>.
- 2. Login to your secure Provider Portal account.
- 3. Click Electronic Funds Transfer located in the Home Page box on the right of the page.

| Wisconsin.gov home state agencies subject directory department of health services   |   |
|---|---|
| ForwardHealth<br>Wisconsin serving you  | Welcome Inpatient03 UAT > May 7, 2019 2:35 PM   |
| Home         Search         Providers         Enrollment         Claims         Prior Authorization         Remittance Advices         Trade Files           Account         Contact Information         Online Handbooks         Site Map         User Guides         Certification  | Health Check Max Fee Home   |
| You are logged in with NPI: 1255334173, Taxonomy Number: 282N00000X, Zip Code: 53226, Financial<br>Payer: Medicaid<br>Providers   | Search Search   |
| Providers can improve efficiency while reducing overhead and paperwork by using real-time applications<br>available on the new ForwardHealth Portal. Submission and tracking of claims and prior authorization<br>requests and amendments, on-demand access to remittance information, 835 trading partner designation,<br>and instant access to the most current ForwardHealth information is now available. | Update User Account Customize Home Page Demographic Maintenance Electronic Funds Transfer Check My Revalidation Date Revalidate Your Provider Enrollment Check Enrollment |
| New Rate Reform Part 3 Ideas/Recommendations Requested.   |   |
| Incentive Payments Are you Eligible?  |   |
| ForwardHealth System Generated Claim Adjustments  | Quick Links   |
|   | Register for E-mail Subscription  |

Figure 22 Electronic Funds Transfer Link

The Introduction page will be displayed.

| Introduction  |
|---|
| Required fields are indicated with an asterisk (*).   |
| For New EFT enrollments or Changes to Existing EFT Enrollments:   |
| You will need to have the following information available:  |
| <ul> <li>The name and email address for the person in your organization that will serve as the contact for a<br/>EFT information.</li> </ul>  |
| <ul> <li>The financial institution's ABA routing number.</li> <li>The account number and the name on record with the bank/financial institution as the Account Holder for the account.</li> </ul> |
| <ul> <li>The type of account (savings or checking, personal or business).</li> </ul>  |
| Existing EFT Data   |
| <ul> <li>Any existing EFT information will be pre-populated based on the current organization you are logged<br/>in with.</li> </ul>  |
| To Check the Status of Your EFT Enrollment:   |
| Click "Next" below and a status screen will appear.   |
| User Guide  |
| • <u>View</u> the EFT user guide.   |
| EFT Processing Overview   |
| <u>View</u> the EFT processing overview.  |
|   |
| <u>N</u> ext Exit <u>C</u>  |

Figure 23 Introduction Page

4. Click **Next**. The Electronic Funds Transfer Request page will be displayed.

| ctronic Fund   | s Transfer Requ     | est     |           |           |               |                 |                           |                |            |              |            |
|--|---------------------|---------|-----------|-----------|---------------|-----------------|---------------------------|----------------|------------|--------------|------------|
| uired fields are                                     | e indicated with a  | nn aste | erisk (*) | ).        |               |                 |                           |                |            |              |            |
|  |                     |         |           |           |               |                 |                           |                |            |              |            |
| • <u>view</u> the Er-1 user guide.                   |                     |         |           |           |               |                 |                           |                |            |              |            |
| <ul> <li>Select the</li> <li>Organization</li> </ul> | organization(s) the | hat you | u want    | to add/c  | s can not be  | changed         |                           |                |            |              |            |
| <ul> <li>To view the</li> </ul>                      | audit history of    | an or   | anizati   | on, selec | t the "View I | History" button | from the list below.      |                |            |              |            |
| in the second second                                 |                     |         |           | .,        |               | ,               |                           |                |            |              |            |
| Organization   | List                |         |           |           |               |                 |                           |                |            |              |            |
| Organizatio  | n List              |         |           |           |               |                 |                           |                |            |              |            |
| Provider ID  | City                | State   | ZIP       | ZIP + 4   | Taxonomy      | Provider Type   | Payer                     | EFT Status     | Add/Change |              |            |
| 000000001  | LADYSMITH           | WI      | 54848     |           | 000N00000X    | Physician Group | Medicaid                  | No EFT on file |            | View History | 1          |
| 000000002  | PLATTEVILLE         | WI      | 53818     | 1264      | 100N00000X    | Hospital        | Medicaid                  | No EFT on file |            | View History |            |
| 000000003  | COTTAGE GROVE       | WI      | 53527     |           | 200N00000X    | Pharmacy        | Medicaid                  | Active         |            | View History |            |
| 000000004  | MIDDLETON           | WI      | 53562     |           | 300N00000X    | Dentist         | Medicaid                  | Active         |            | View History |            |
| 000000005  | LADYSMITH           | WI      | 54848     |           | 400N00000X    | Physician Group | Medicaid                  | No EFT on file |            | View History |            |
| 000000006  | GREEN BAY           | WI      | 54305     |           | 500N00000X    | Hospital        | Wisconsin Chronic Disease | No EFT on file |            | View History |            |
|  |                     |         |           |           |               |                 |                           |                |            |              | Select All |
|  |                     |         |           |           |               |                 |                           |                |            | -            |            |
|  |                     |         |           |           |               |                 |                           |                |            |              |            |
| Audit History  |                     |         |           |           |               |                 |                           |                |            |              |            |
| A  |                     | _       | _         | _         | _             |                 |                           |                |            | _            | _          |
| *** No rows for                                      | y<br>nd ***         |         |           |           |               |                 |                           |                |            |              |            |
| 101013100  |                     |         |           |           |               |                 |                           |                |            |              |            |
|  |                     |         |           |           |               |                 |                           |                |            |              |            |
|  |                     |         |           |           |               |                 |                           |                |            |              |            |
|  |                     |         |           |           |               | Browieurs       | Next                      |                |            |              | p          |
|  |                     |         |           |           |               | Previous        | Mext                      |                |            |              | Exit       |

Figure 24 Electronic Funds Transfer Request Page

If you are an EFT clerk, this page will display all the service locations for which you are assigned the EFT role. Account administrators will see all of the service locations for the provider under which they are logged in.

- 5. Verify that the EFT account you wish to change is in an *Active* status.
- 6. Check the Add/Change box for each service location that you wish to modify. If all the service locations listed are to be modified, click **Select All** to check all the boxes.

Note: When more than one service location is selected, all the information revised in the succeeding pages will apply to all the service locations selected. If there is any difference in the EFT information used between service locations, including demographic information, email addresses, ABA routing numbers, EFT settlement account numbers, and account types, the service locations must be revised separately.

7. Click **Next**. The General Information page will be displayed.

| General Information  | 0  |
|--|--|
| Required fields are indicated with   | an asterisk (*).   |
| <ul> <li><u>View the EFT User Guide</u></li> <li>If you need to change the through the portal.</li> </ul>  | tax information below, please go to the <u>Demographic Maintenance Tool</u> to submit your new information |
| Pay To Address   |  |
| Name - Business or Individual  | STATE UNIVERSITY   |
| Street Address Line 1  | 123 MAIN STREET  |
| Street Address Line 2  | MEDICAL FOUNDATION   |
| City   | ANYTOWN  |
| State/ZIP  | WI 💙 55555 -   |
| Contact Information<br>Name - Contact Person* JANI<br>Primary E-mail Address* jane<br>Telephone Number* (608<br>Fax Number (608<br>Other EFT Contact Notificat<br>E-mail Address 1 john.smith@<br>E-mail Address 2<br>E-mail Address 3<br>E-mail Address 4 | E DOE<br>. doe@abc.com<br>3)555-5555 Ext.<br>3)555-5555<br>ion Addresses<br>Dxyz.com                       |
| Tax Identification Information<br>Taxpayer Identification Numbe<br>Name - FEI  | n (TIN) 00000000<br>N/SSN IM A. PROVIDER   |
|  | Previous Next Exit   |

Figure 25 General Information Page

8. If you are not changing any information on this page, click **Next**.

To make any changes to the "Contact Information" or "Other EFT Contact Notification Addresses" sections, enter the changes in the appropriate fields. Once the information has been entered, click **Next**.

The Financial Institution Information page will be displayed.

| Financial Institution Information   | 3                       |
|---|-------------------------|
| Required fields are indicated with an asterisk (*).   |                         |
| • <u>View</u> the EFT user guide.   |                         |
| C Search Criteria   |                         |
| ABA Routing Number  |                         |
| Financial Institution Name  |                         |
|   | Search <u>*</u>         |
|   |                         |
| Search Results  |                         |
| Financial Institutions  |                         |
| ABA Number         Name         Address Line 1         City         State           070707070         GENERAL BANK GREEN BAY, N.A.         GREEN BAY         WI | <u>ZIP</u> <u>ZIP+4</u> |
|   |                         |
| Selected Financial Institution  |                         |
| ABA Routing Number 070707070  |                         |
| Financial Institution Name GENERAL BANK GREEN BAY, N.A.   |                         |
| Address Line 1  |                         |
| Address Line 2  |                         |
| City GREEN BAY  |                         |
| State/ZIP WI -  |                         |
| Telephone Number Ext.   |                         |
|   |                         |
| Previous Next   | Exit C                  |

Figure 26 Financial Institution Information Page

9. If you are not changing any information on this page, click **Next**.

To change the financial institution receiving the EFT payment, enter the ABA routing number or name of the financial institution in the "Search Criteria" section and click **Search**. A list of the available financial institutions matching your search criteria will be displayed in the "Search Results" section. From the displayed list, click the financial institution whose information matches the ABA routing number, name, and address of the institution that your organization has an account with and that your organization wishes to designate as your new ForwardHealth EFT financial institution. Information for the selected financial institution will be displayed in the "Selected Financial Institution" section. Verify that the populated information is correct. Click **Next**.

The Account Information page will be displayed.

| Account Information           |  | ? |
|-------------------------------|--|---|
| Required fields are indicated | with an asterisk (*).                            |   |
| • <u>View</u> the EFT user gu | ide.   |   |
| Account Information           |  |   |
| Customer Account Nu           | mber* 111111111                                  |   |
| Type of Acc                   | ount* <sup>C</sup> Checking <sup>C</sup> Savings |   |
| Business or Personal Acc      | ount* 💽 Business 🗋 Personal                      |   |
| Account Holder Inform         | ation  |   |
| Name - Account Holder*        | JANE DOE   |   |
| Street Address Line 1*        | 7 CHERRY TREE LANE                               |   |
| Street Address Line 2         |  |   |
| City*                         | MADISON  |   |
| State/ZIP*                    | WI <b>v</b> 55555 -                              |   |
| Telephone Number*             | (608)555-5555 Ext.                               |   |
|                               |  |   |
|                               |  |   |
|                               | Previous Next Exit (                             |   |

Figure 27 Account Information Page

10. If you are not changing any information on this page, click **Next**.

If you have changed to another financial institution, enter the provider's account information in the appropriate fields. If you are revising information for the provider's current institution, make the necessary changes. Click **Next**.

The Authorization to Make Electronic Fund Payments page will be displayed.

| Authorization to Make Electronic Fund Payments   | ?             |
|--|---------------|
| Required fields are indicated with an asterisk (*).  |               |
| View the EFT user guide.   |               |
|  |               |
| Authorization  |               |
| On behalf of the health care provider identified above, by my signature below I hereby represent as follows:   |               |
| <ol> <li>I authorize the Department of Health Services (DHS) to deposit, by electronic funds transfer, payments own to the provider by the State of Wisconsin and, if necessary, initiate debit adjustments for any electronic deposits made in error to the account indicated above. I hereby authorize the financial institution/bank named above to credit and/or debit the same to such account.</li> <li>I acknowledge that funds deposited pursuant to this authorization are payments by the State of Wisconsin and are subject to the same laws, rules and policies as payments made in any other manner.</li> <li>I acknowledge that if the provider fails to provide complete and accurate information on this authorization form, the processing of the form may be delayed or my payments may be ernoeusly transferred electronically. In the event that due to failure to provide complete or accurate information DHS deposits payments into an account over which the provider dees not have control. I agree that DHS shall be held harmless for such payments.</li> <li>I hereby certify that the provider has control of the account referenced above, and that the financial institution and all arrangements between the financial institution and the provider are in compliance with all applicable federal and Automated Clearing House (ACH) regulations and instructions.</li> <li>I acknowledge that any information provided in this document constitutes a statement or representation of material fact knowingly and willfully made or caused to be made for use in determining rights to payment within the meaning of s.49.49(1) and (4m), Wis. Stats., and that if any such information is false, criminal or other penalties may be imposed under those laws.</li> <li>I acknowledge that this authorization is effective as of the signature date below and will remain in full force and effect until the DHS has received written notification from an authorized representative of provider at least thirty (30) days in advance of its termination. The DHS will</li></ol> | a             |
|  |               |
| Previous Next  | Exit <u>C</u> |

Figure 28 Authorization to Make Electronic Fund Payments Page

- 11. Read the Authorization statement.
- 12. Check the box next to "I Agree to the statements above."
- 13. Enter your signature, title, and the date.

Note: This is a legally binding agreement.

14. Click **Next**. The Summary page will be displayed.



Figure 29 Summary Page

15. To preview your request, click **Preview EFT Request**. A draft PDF version of your EFT request(s) will be displayed in a separate window. Each agreement consists of two pages. (Multiple EFT requests will be displayed in one PDF.)

| DEPARTMENT OF<br>Division of Health Co<br>5-13468 (05/09) | HEALTH SERV<br>are Access and                      | Accountability                                 |                                     |             |                             |                     | STATE C             | FWISCONSIN         | DIRECT DEPOSIT AUTHORIZATION FOR ELECTRON<br>F-13468 (0209)  | C FUNDS TRANSFER (EFT) REQUEST   | Page 2 d  |
|---|--|--|-------------------------------------|-------------|-----------------------------|---------------------|---------------------|--------------------|--|--|---|
|   |  |  | FC                                  | RWARD       | HEALTH                      |                     |                     |                    | SECTION VII — AUTHORIZATION TO MAKE EI<br>On behalf of the health care provider identified ab  | ECTRONIC FUND PAYMENT8<br>ove. by my signature below I hereby represent as follows:  |   |
| DIRECT DE<br>Instructions: Typ<br>EFT) Request Co         | e or print clea<br>impletion instr                 | JTHORIZA<br>rly. Before con<br>ructions, F-134 | TION FOI<br>npieting this 1<br>68A. | R ELEC      | TRONIC FU                   | INDS TRANS          | FER (EFT) RE        | EQUEST<br>Transfer | <ol> <li>I authorize the Department of Health Services<br/>State of Wisconsin and, if necessary, initiate debi<br/>above. I hereby authorize the financial institution?</li> </ol> | DH8) to deposit, by electronic funds transfer, payments ow<br>adjustments for any electronic deposits made in error to th<br>ank named above to credit and/or debit the same to such a | ed to the provider by th<br>e account indicated<br>account. |
| New EFT E   | ASON FOR R<br>Inrolment                            | EQUEST   |                                     |             |                             |                     |                     |                    | <ol><li>I acknowledge that funds deposited pursuant t<br/>same laws, rules and policies as payments made</li></ol>   | b this authorization are payments by the State of Wisconsin<br>in any other manner.  | and are subject to the                                      |
| EFT Termin  | ation Reques                                       | t  |                                     |             |                             |                     |                     |                    | <ol> <li>I acknowledge that if the provider fails to provid<br/>the form may be delayed or my payments may be</li> </ol>   | e complete and accurate information on this authorization f<br>erroneously transferred electronically. In the event that du  | e to failure to provide                                     |
| SECTION II - PR   | ROVIDER LOC  | CATIONS / CE                                   | RTIFICATIO                          | NS IMPAC    | TED                         |                     |                     |                    | complete or accurate information DHS deposits p<br>DHS shall be held harmless for such payments  | ayments into an account over which the provider does not h   | ave control, I agree that                                   |
| For Health Care H   | Providers  |  |                                     | <u> </u>    |                             | -                   | Paver               |                    |  |  |   |
| NPI* or<br>Provider ID                                    | Name   | Address  | City                                | State       | ZIP Code                    | Code                | (MA, WWWP,<br>WCDP) | SSN or<br>EIN      | <ol> <li>I hereby certify that the provider has control of<br/>arrangements between the financial institution an<br/>House (ACH) regulations and instructions.</li> </ol>          | the account referenced above, and that the financial institu<br>d the provider are in compliance with all applicable federal a   | tion and all<br>and Automated Clearing                      |
| 00000001  |  |  |                                     |             | 53618                       | 100000000           | MA                  | 123450789          | 5 Lacknowledge that any information provided in  | this document constitutes a statement or representation of   | a material fact   |
|   |  |  |                                     |             |                             |                     |                     |                    | knowingly and wilfully made or caused to be mad<br>(4m). Wis, State, and that if any such information  | e for use in determining rights to payment within the meaning factor of the meaning factor of the penalties may be imposed under   | ng of s.49.49(1) and<br>those laws.                         |
| A National Pro  | vider identifier                                   | r (NPI) is requi                               | red for all hea                     | ith care pr | roviders. Non-he            | althcare providers  | may enter their M   | edicaid            | <ol> <li>I acknowledge that this authorization is effective<br/>DHD by perceived writes patients.</li> </ol>   | e as of the signature date below and will remain in full force   | and effect until the  |
| SECTION III - P   | AY TO ADDR   | ESS ON FILE                                    | FOR LOCAT                           | IONS / CE   | RTIFICATIONS                | LISTED ABOVE        | Must Be the Sam     | e Address for      | termination. The DHS will continue to send the dir   | ect deposit to the financial institution indicated above until   | otified in accordance                                       |
| Al Locations)   |  |  |                                     |             |                             |                     |                     |                    | with this paragraph by an authorized representativ   | e of provider that provider wishes to change the financial in  | stitution receiving the                                     |
| ame — Business  | s or individual                                    |  |                                     |             |                             |                     |                     |                    | Agreement.   | es, provider agrees to submit to the DHS an updated EPT  | Autorization  |
| COUNTY OF   | <ul> <li>NELSON</li> <li>ss or individu</li> </ul> | al (Street, City                               | State, ZIP (                        | (ade)       |                             |                     |                     |                    | 7. I acknowledge that the requirements and oblig   | ations contained herein are in addition to any and all other   | requirements and  |
| 900 NELSON  |  | ATTEVI   | ILE WI                              | 5381        | 8                           |                     |                     |                    | obligations applicable to provider in connection w   | th provider's participation in any program that is part of For   | wardHealth, including                                       |
| SECTION IV - C  | ONTACT INF   | ORMATION F                                     | OR EFT NOT                          | IFICATIO    | N                           |                     |                     |                    | and updates.   | from in receral and state statutes and rules and applicable  | provider handbooks  |
| Name — Contact I  | Person   |  |                                     |             | E-mail Addr                 | ess — Contact Per   | son                 |                    |  |  |   |
| JANE DOE  |  |  |                                     |             | jane.do                     | e@abc.com           |                     |                    | <ol> <li>Tam an authorized representative or the provid</li> </ol>   | er with power to make all representations on provider's per  | ar contained herein.  |
| felephone Numbe   | er — Contact P                                     | Person   |                                     |             | Fax Number                  | r - Contact Perso   | 1                   |                    | SIGNATURE — Authorized Agent   | Name — Authorized Agent (Printed)  |   |
| (920) 123-45  | 67   | E  | ant 1111                            |             | (608) 11                    | 1-2345              |                     |                    | Jane Doe   |  |   |
| SECTION V - FI  | NANCIAL INS  | STITUTION IN                                   | FORMATION                           |             |                             |                     |                     |                    | Title  | Date Signed  |   |
| Name — Financia   | Institution  |  |                                     |             |                             |                     |                     |                    | Finance Director   | 07/28/2011   |   |
| <b>BENERAL B</b>  | BANK GRE   | EN BAY, N                                      | N.A.                                |             |                             |                     |                     |                    | SIGNATURE — Authorized Agent (optional)  | Name — Authorized Agent (Printed)  |   |
| Address — Finance<br>ODEENIDA                             | V MI   | (Street, City, S                               | itate, ZIP Co                       | ie) 1       | Type of Account<br>Checking |                     | Business or Pers    | onal Account:      |  |  |   |
| , OREEN DA  |  |  |                                     | j l         | Other (spect                | V):                 | Personal            |                    | Tite   | Date Signed  |   |
| Contact Name —  | Financial Inst                                     | tution   |                                     | 1           | Telephone Num               | ber — Financial Ins | tution              |                    |  |  |   |
| ABA Routing Num   | ber (Nine Dig                                      | (t)  |                                     |             | Customer Accou              | nt Number           |                     |                    |  |  |   |
| 075900575   |  |  |                                     |             | 123456789                   | 12111213            |                     |                    | Internal Use Only<br>Audit - Liver Name  | Audit - Line ID  |   |
| SECTION VI - A  | CCOUNT HO  | LDER INFOR                                     | MATION                              |             | 120100100                   |                     |                     |                    |  |  |   |
| Name — Account  | Holder   |  |                                     |             | Telephone                   | Number — Accour     | it Holder           |                    | Test Provider  | PROV1UAT   |   |
| IMIN CHARGE (608  |  |  |                                     | (608) 58    | (608) 555-1212 Ext. 1       |                     |                     | Audix - Date/Time  |  |  |   |
| Address — Accou   | nt Holder (Str                                     | eet, City, State                               | , ZIP Code)                         |             |                             |                     |                     |                    | Thursday, July 28, 2011 9:29:11 AM   |  |   |
| 123 VP LAN  | E, MADISO  | ON, WI 537                                     | 19-1234                             |             |                             |                     |                     |                    |  |  |   |
|   |  |  |                                     |             |                             | -DF                 | RAF                 | Continued          |  | -DR/   | AFT-  |
|   |  |  |                                     |             |                             |                     |                     |                    |  |  |   |

Figure 30 Draft PDF Version of EFT Request

Note: Do *not* print and fax or mail these requests to ForwardHealth. ForwardHealth does not accept paper enrollments. The enrollment will be submitted when you click Submit on the Summary page.

- 16. Verify that the information displayed in the draft PDF version is accurate. To make changes to an EFT request, click **Previous** until you return to the appropriate page. Change the necessary information.
- 17. Click **Submit** on the Summary page to submit the EFT enrollment request(s). The EFT Request was Submitted page will be displayed.



Figure 31 EFT Request Was Submitted Page

The EFT Request was Submitted page confirms that your EFT request(s) was submitted successfully and describes the next steps.

- 18. To save a copy of your EFT request(s) for your records, click **Save**. A draft PDF version of your EFT request(s) will be displayed in a separate window.
- 19. Click **Exit**. You will be redirected to the secure Provider page.

# **5** Email Notifications

An EFT contact will receive an email notification in the following situations.

## **5.1 Change of Email Address**

When the email address for an EFT contact is changed, an email message is sent to the original address, alerting the contact that the address has been changed in ForwardHealth's records. The message also indicates that the EFT contact should alert the provider's account administrator immediately if the change was made in error.

The message contains the following contact information in order to verify the correct address was changed:

- Provider ID/National Provider Identifier (NPI).
- Taxonomy number (if applicable).
- ZIP code.
- Financial payer.

## 5.2 Change of Electronic Funds Transfer Bank Information

When EFT bank information is changed, an email message noting that the key EFT account information (such as financial institution, account number, account type, account holder's name) has been changed is sent to the provider's EFT contact. In addition, an email message indicating that EFT information has been revised will be sent to the provider's account administrator's messaging account.