CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15609 SACRAMENTO,
CALIFORNIA 95852-0609
Phone: 800-423-0507 Web: www.dental.dhcs.ca.gov

ELECTRONIC FUNDS TRANSFER (EFT) ENROLLMENT FORM

PROVIDER INFORMATION

1.Legal Name of the Provider (as listed with IRS):

2. Business Name/Fictitious Name:

3. Service Office Address – Street:

4. City:

5. State/Province:

6. ZIP Code/Postal Code:

PROVIDER IDENTIFIERS INFORMATION

7. Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):

8. Service Office National Provider Identifier (NPI):

PROVIDER CONTACT INFORMATION

9. Provider Contact Name:

10. Telephone Number:

11. Email Address:

FINANCIAL INSTITUTION INFORMATION

12. Financial Institution Name:

13. Financial Institution Routing Number (nine-digit number located to the left of the account number):

14. **Type of Account at Financial Institution:** ❍ Checking ❍ Savings

15. Provider's Account Number with Financial Institution:

16. **Reason for Submission:** ❍ New Enrollment ❍ Change Enrollment ❍ Cancel Enrollment

17. . **INCLUDE WITH ENROLLMENT SUBMISSION**

ORIGINAL PRE-IMPRINTED VOIDED CHECK

***** TAPE HERE OR ATTACH BANK LETTER *****

18.

Authorized Signature - Written Signature of Owner(s)/Officer(s) **Submission Date**

19. **Printed Name of Owner(s)/Officer(s)**

Mail the completed form to: Medi-Cal Dental Program, Attention: Provider Enrollment Department, P.O. Box 15609, Sacramento, CA 95852-0609.
To check status, including late or missing payments* please contact the Medi-Cal Dental Telephone Service Center (TSC) at (800) 423-0507.

Late or missing is defined as a maximum elapsed time of four business days following the receipt of the associated v5010X12 835 transaction.

For Medi-Cal Dental Use Only: *Date Entered:* *Initials:*

Instructions for Completing the Electronic Funds Transfer (EFT) Enrollment Form

By submitting this form, the provider is authorizing Medi-Cal Dental to electronically post earnings into their designated account.

For assistance in completing the Electronic Funds Transfer (EFT) Enrollment form, please contact the Medi-Cal Dental TSC at (800) 423-0507. These instructions may also be found in the Providers Application Forms section on the Medi-Cal Dental website at www.dental.dhcs.ca.gov.

PROVIDER INFORMATION

1. Enter the legal business name of the provider as listed with the Internal Revenue Service (IRS)
2. If using a fictitious name, enter the fictitious name as listed with the Dental Board of California
3. Enter the provider service office street address
4. Enter the service office city
5. Enter the service office state
6. Enter the service office zip code

PROVIDER IDENTIFIERS INFORMATION

7. Depending on how earnings are reported enter the provider tax identification number (TIN) or Employer Identification number (EIN) or Social Security Number (SSN)
8. Enter the provider National Provider Identifier (NPI) for the service office location

PROVIDER CONTACT INFORMATION

9. Enter the contact's name
10. Enter the telephone number for the service office
11. Enter the provider email address

FINANCIAL INSTITUTION INFORMATION

12. Enter the name of the financial institution (Bank) name
13. Enter the routing number for the provider financial institution the routing number is a nine-digit number and is located to the left of the account number

TYPE OF ACCOUNT AT FINANCIAL INSTITUTION

14. Check the box for "Checking" or "Savings"
15. Enter the account number

REASON FOR SUBMISSION

16. Check the EFT action "New Enrollment", "Change Enrollment" or Cancel Enrollment"

OTHER

17. Attach a pre-imprinted voided check to the form in the blank space provided or include a letter from the bank signed by an authorized agent confirming the provider account information to include: Name on the account, Account Number, American Bankers Association Routing Number and the Account Number.
18. Sign and date the EFT form; requires all owner's or officer's original signature.
19. Print the name of the owner(s) or officer(s) signing the form.

Mail the completed form to: Medi-Cal Dental Program
Attention: Provider Enrollment Department
P.O. Box 15609
Sacramento, CA 95852-0609.

To check status and resolve a late or missing Healthcare EFT Standards payment, please contact the Medi-Cal Dental TSC at (800) 423-0507. Late or missing is defined as a maximum elapsed time of four business days following the receipt of the associated v5010X12 835 transaction.

Instructions for Completing the Electronic Funds Transfer (EFT) Enrollment Form

Providers can request a receipt of the information provided in the Corporate Credit or Debit Entry (CCD)+ addenda record of EFT transactions from their financial institutions. This addenda record includes the Medi-Cal Dental assigned check number and the Medi-Cal Dental Tax ID number. Providers can then use this information to reconcile EFT payments with their X12 835 Electronic Data Interchange (EDI) transactions.

To maximize the benefits available through the CAQH CORE Reassociation Rule, providers must reach out to their financial institution and request that the necessary data for reassociation of an EFT and Electronic Remittance Advice (ERA) be sent with each payment. Providers may use the sample letter below as a template that can be customized and provided to bank contacts. For assistance in completing the Electronic Remittance Advice (ERA) Enrollment form, please contact Medi-Cal Dental EDI Support at (916) 853-7373 (e-mail: Medi-CalDentalEDI@delta.org).

SAMPLE LETTER FROM PROVIDER TO FINANCIAL INSTITUTION
TO REQUEST RECEIPT OF THE NACHA CCD+ ACH PAYMENT RELATED INFORMATION

<*date*>

key contacts at financial institution
key contacts job title>
financial institution name>
<
<
<

Re: Request for ACH Payment Related Information for <*Account Name and Account Number*> Dear

<*key contacts at financial institution*>,

The Affordable Care Act (ACA) mandates Healthcare Operating Rules to support the adoption of electronic payments across the healthcare industry. <*name of provider organization*> would like to benefit from the Healthcare Operating Rules which assist providers in automating reassociation of EFT payments and electronic remittance advices.

The *NACHA Operating Rules*, which align with the Healthcare Operating Rules, require a Receiving Depository Financial Institution (RDFI) to provide or make available, either automatically or upon request, all data contained within the ACH Payment Related Information field (including the TRN Reassociation Trace Number) of the Addenda Record, no later than the opening of business on the second Banking Day following the Settlement Date. The NACHA rules also require the RDFI to offer or make available to the healthcare provider an option to receive or access the Payment Related Information via a secure, electronic means. This change to the *NACHA Operating Rules* was made to support changes in the healthcare industry due to the ACA.

The purpose of this communication is to formally request receipt of ACH Payment Related Information for all CCD+ EFT payments received by <*name of provider organization*> for <*Account Name and Account Number*> to enable reassociation of EFT payments with electronic remittance advices. Please provide <*name of provider organization*> additional information on our options to receive secure, electronic delivery of the ACH Payment Related Information for including:

<*Note from CAQH CORE: the below list is only an example of the types of things your organization may want to consider asking about and may be customized*>

- Options for receiving the ACH Payment Related Information
- Approaches for testing the electronic delivery method to receive the ACH Payment Related Information
- Information regarding to the length of time to implement delivery of the ACH Payment Related Information
- Information about any fees associated with establishing electronic delivery of the ACH Payment Related Information

Thank you in advance for your assistance. If you should have any questions, please contact <*key contact at provider organization*> at XXX-XXX-XXXX. If we do not receive a response, we will follow-up on this <*email/letter*> via phone in one week.

Sincerely,

<*your name*>
<*your job title*>
<*name of provider organization*>
<*your phone number*>