



DIRECT DEPOSIT AUTHORIZATION / AGREEMENT FORM

(Page 1 of 4)

Make one copy of this form for your records and mail or fax the form with a copy of a pre-printed voided check for the account to:

Mississippi Medicaid Program

Provider Enrollment

P.O. Box 23078

Jackson, Mississippi 39225

Fax: (866) 644-6148

NOTE: Because of the Federal Cash Management Act, it is necessary for the Division of Medicaid to mandate the Direct Deposit of Medicaid payments to all Medicaid providers. With the weekly average Medicaid provider payments exceeding \$20 million, without Direct Deposit the interest to the Federal government would have to be paid from all State funds that would otherwise be used to match federal funds to make provider payments. Given Mississippi's favorable federal match rate, this would have the potential of reducing total program dollars by more than \$10 million per year. This process has been underway since October 26, 1992, and has proven to be beneficial to both the State of Mississippi and the Medicaid providers. Please complete this form in order for us to complete your enrollment process and begin depositing your funds electronically. **Alert: If you choose not to complete this agreement you will not be assigned a Mississippi Medicaid Provider Number.**

You may contact the Division of Medicaid's Fiscal Agent, Gainwell Technologies, at (800) 884-3222, Monday- Friday 8AM-5PM CST if you have any questions about the Direct Deposit Authorization/Agreement Form or wish to inquire upon the status of a form that has already been submitted.

Instructions for filling out this form are provided at the end. Required fields are denoted with an asterisk (*).

Provider Information

Provider Name*

Vicksburg Warren County Ambulance Service

Provider Identifiers Information

Provider's Federal Tax Identification Number, Employer Identification Number (EIN) or Social Security Number (SSN) *

6 4 6 0 0 1 1 7 4

National Provider Identifier (NPI)*

1 3 6 6 5 0 4 8 4 7

Provider Contact Information

Provider Contact Name

Tracy Wold

Title

Compliance Officer

Telephone Number

3 1 8 5 4 8 1 0 9 3

Telephone Number Extension

Email address

tracy@itastrategies.com

Fax Number

318-404-1600

Financial Institution Information

Financial Institution Name*

Huntington Bank

Financial Institution Address

Street

820 South Street

City

Vicksburg

State

MS

Zip

39180



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Financial Institution Routing Number*

044000024

Type of Account at Financial Institution*

☒ Checking

☐ Savings

Provider's Account Number with Financial Institution*

01468300040

Submission Information

Reason for Submission*

☐ New Enrollment

☒ Change Enrollment

Authorized Signature

I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents; or concealment of a material fact, may be prosecuted under applicable federal or state laws. I further authorize the Mississippi Division of Medicaid to present credit entries (deposits) into the bank account referenced above and depository named above. These credits will pertain only to direct deposit transfer payments for Medicaid services that the payee has rendered. **I further understand that in the event my bank account information was to change, I must notify the Mississippi Division of Medicaid in order to change my bank account information immediately. I will not hold the Mississippi Division of Medicaid liable for presentation of any and all credit entries (deposits) into the bank account referenced above and the depository named above if I fail to notify the Division of Medicaid or the fiscal agent of my change in bank account information.**

Signature of Authorized Official or Individual Provider*

Printed Name of Authorized Official or Individual Provider

Mavor Willis Thomson

Submission Date



DIRECT DEPOSIT AUTHORIZATION / AGREEMENT FORM (Page 3 of 4)

INSTRUCTIONS

Required fields are denoted with an asterisk (*).

Provider Information

Provider Name* - If the provider is an individual, enter the provider's name. If the provider is a group/facility or other provider types, enter the business name.

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)* - Enter the Federal Tax Identification Number (TIN) or the Employer Identification Number (EIN), if available. If the provider is an individual who doesn't have a Federal Tax Identification Number (TIN), or Employer Identification Number (EIN), enter the provider's own Social Security Number in the TIN/EIN field.

National Provider Identifier (NPI)* - Enter the provider's National Provider Identifier Number. If you are a Non-Healthcare Provider without an NPI, enter 10 zeros in the NPI field.

Provider Contact Information

Provider Contact Name* - Enter the name of the person to be contacted for questions or clarification.

Title - Enter the title of the Provider Contact person.

Telephone Number - Enter the telephone number, including area code, of the Provider Contact Person.

Telephone Number Extension - Enter the telephone number extension of the Provider Contact Person, if applicable.

Email address - Enter the email address of the Provider Contact Person.

Fax Number - Enter the fax number of the Provider Contact Person.

Financial Institution Information

Financial Institution Name* - Enter the name of the financial institution that is to receive the provider's payments.

Financial Institution Address (Street) - Enter the street address of the financial institution.

Financial Institution Address (City) - Enter the city address of the financial institution.

Financial Institution Address (State) - Enter the two digit state abbreviation of the financial institution.

Financial Institution Address (Zip) - Enter the zip code address of the financial institution.

Financial Institution Routing Number* - Enter the nine digit routing number of the financial institution.

Type of Account at Financial Institution* - Check the Checking radio button if the account at the financial institution is a checking account. Check the Savings radio button if the account is a savings account.

Provider's Account Number with Financial Institution* - Enter the provider's account number with the financial institution.



DIRECT DEPOSIT AUTHORIZATION / AGREEMENT FORM (Page 4 of 4)

INSTRUCTIONS

Required fields are denoted with an asterisk (*).

Submission Information

Reason for Submission* - Check the New Enrollment radio button if this application is to enroll a new provider for EFT. Check the Change Enrollment radio button if this application is to make a change to an existing provider's EFT information.

Authorized Signature

Signature of Authorized Official or Individual Provider* - If the form submitted is to update an individual provider file, the individual provider must sign. If the form submitted is for a group/facility/other business, an authorized official noted on the provider file must sign the form.

Printed Name of Person Submitting Enrollment – Enter the name of the individual provider or the authorized person who signed the form.

Submission Date – Enter the current date.

Missing or Late EFT Procedures

- The provider should contact the Division of Medicaid's Fiscal Agent, Gainwell Technologies, at (800) 884-3222 to verify their banking information that is currently on file.
- The Call Center Agent will verify the banking account and routing numbers.
- If the account number is correct, the Call Center Agent will advise the provider to contact their financial institution's ACH department.
- If the banking account or routing number isn't correct, the Call Center Agent will direct the provider to update their banking account information via this Direct Deposit Authorization/Agreement form which is available on the Mississippi Medicaid website at [Forms - Mississippi Division of Medicaid](#) under Provider Enrollment Forms.