DEPARTMENT FOR MEDICAID SERVICES
DIRECT DEPOSIT AUTHORIZATION/CANCELLATION FORM

Complete the following provider information:

Provider Name: _____

Provider Number: _____NPI (National Provider Identifier) _____

Address: _____

City: _____State: _____ Zip: _____

Telephone Number: _____Contact Name _____

☐ **New Enrollment** ☐ **Institution or Account Change**

Bank Name _____

Branch or correspondent Bank (if applicable) _____

City _____ State: _____ Zip:_____

Transit/ABA Number: _____Account Number: _____

Account Type (select one): ☐ Checking ☐ Savings

I, the undersigned, authorize the Department for Medicaid Services to initiate accounting transactions to deposit payments directly to the account indicated above. These deposits will pertain only to direct deposit payments for Medicaid services that the payee has rendered.

I understand that in the event that my account information should change, I must notify the Kentucky Medicaid agency immediately. I will not hold the Kentucky Medicaid agency liable for presentation of any or all direct deposits into the account indicated above if I fail to notify Kentucky Medicaid or the fiscal agent of my change in bank account information.

I understand in endorsing or depositing this check (EFT) that payment will be from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.

Signature _____Date: _____

Title _____

☐ **Cancellation**

I, the undersigned, hereby cancel the authorization for the Department for Medicaid Services to originate direct deposit entries into my checking/savings account. This cancellation is effective on date of receipt.

Signature: _____Date: _____

Title: _____

INSTRUCTIONS FOR DIRECT DEPOSIT AUTHORIZATION/CANCELLATION FORM

FIELD NAME	FIELD INSTRUCTION
Provider Name	Enter the personal or business name.
Provider Number	Enter the KY Medicaid provider number assigned to the provider for services rendered to KY Medicaid members.
NPI (National Provider Identifier)	Enter the provider's NPI.
Address	Enter the physical address.
City	Enter the physical city.
State	Enter the physical state.
Zip	Enter the physical zip code.
Telephone Number	Enter the telephone number where the provider can be reached during normal business hours.
Contact Name	Enter the name of the individual that can be contacted at the number indicated above.
New Enrollment/Institution or Account Change	Indicate by marking the appropriate block if this form is for a new enrollment or a change to previous information.
Bank Name	Enter the name of the provider's financial institution.
Branch or Correspondent Bank	Enter branch name or major bank or the provider's financial institution if applicable.
City, State, Zip	Enter physical city, state, and zip where the financial institution indicated above is located.
Transit/ABA Number	Enter the nine digit American Banking Association (ABA) identifying number for the financial institution indicated above. This number can be obtained from the institution or is normally the first nine digits of the electronic coding at the bottom of the check or deposit slip.
Account Number	Enter the provider's account number at the financial institution indicated above.
Account Type	Indicate by marking the appropriate block whether you would like the funds be deposited into checking or savings account.
Signature	Signature of provider or authorized representative of the provider.
Date	Date this form is signed.
Title	Title of the individual signing this form.
Cancellation Block	If you wish to cancel the direct deposit, please mark the cancellation box and sign and date form.
Signature	Signature of provider or authorized representative of the provider.
Date	Date this form is signed.
Title	Title of the individual signing this form.

SUBMIT COMPLETED FORM TO:

KY Medicaid
P.O. Box 2110
Frankfort, KY 40602-2110
Telephone: 877-838-5085