Electronic Funds Transfer (EFT) Authorization Form

Instructions: Carefully read and complete the entire authorization form. Mail the completed form to

Magellan Medicaid Administration, Inc.
Provider Operations Department
11013 W. Broad Street
Suite 500
Glen Allen, VA 23060

Type or print the following information.		
BUSINESS NAME OF PHARMACY:		
NABP OR NPI NUMBER (IF CHAIN, NOTATE PAYSITE, IF KNOWN):	**PHONE NUMBER:**	
EMAIL ADDRESS		
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP:**
NAME OF FINANCIAL INSTITUTION:		
ACCOUNT TYPE: MUST BE CHECKING		
*ACCOUNT NUMBER (UP TO 17 CHARACTERS):		
ABA ROUTING NUMBER (9 DIGITS):		
CONTACT PERSON:		

Type of Authorization (select only one)

☐ **NEW** - Select if establishing Electronic Fund Transfer (EFT) payments. Allow a minimum of 16 days for the EFT to begin.
Please attach a voided check from the account in which you want payments deposited.

☐ **CHANGE** - Select if changing financial institution, account number, or type of account, etc. *Do Not Close Your Old Account Until This Change Takes Place*. Allow a minimum of 16 days for the EFT change to become effective.
Please attach a voided check from the account in which you want payments deposited.

☐ **CANCEL** - Select if you want to cancel EFT payments. You may also cancel EFT payments by calling the Magellan Medicaid Administration Provider Operations Department at 888-868-9219. Allow a minimum of 16 days for the cancellation to take effect.
If you plan to close your bank account, do not do so until so until your last payment has been deposited.

* At financial institution
** Contact your financial institution for the routing number, if not already known

MAGELLAN PHARMACY SOLUTIONS | MAGELLAN MEDICAID ADMINISTRATION

Authorization

I authorize Magellan Medicaid Administration and the State of Michigan to make deposits by electronic transfer to the designated financial institution and account identified above.

I authorize Magellan Medicaid Administration to collect money that was deposited in my account in error by electronically adjusting my account. I understand I will be notified by Magellan Medicaid Administration if adjustments are made.

It is my responsibility to complete a new Electronic Funds Transfer form and mail it to the address above if I change financial institutions or account numbers. If I am changing financial institutions or closing my account, I will not close my old account until final payments are successfully deposited into the new account.

If multiple account holders are required to authorize a deposit or withdrawal of funds, then all parties must sign this authorization form.

PRINT NAME **TITLE**

SIGNATURE **DATE**

PRINT NAME **TITLE**

SIGNATURE **DATE**

PRINT NAME **TITLE**

SIGNATURE **DATE**

PRINT NAME **TITLE**

SIGNATURE **DATE**