MISSOURI DEPARTMENT OF SOCIAL SERVICES (DSS)
MO HEALTHNET DIVISION (MHD)

APPLICATION FOR PROVIDER DIRECT DEPOSIT

AUTOMATED CLEARING HOUSE (ACH) ACCOUNTS ONLY, WIRE TRANSFER IS NOT AVAILABLE

SECTION A Type or print in medium black ink – all sections must be completed

1. TYPE OF ACTION ► ❑ Provider Applicant ❑ Enrolled Provider ❑ Change Account/Route Number(s)

2. PROVIDER NAME: Complete provider name as licensed, certified, or, if currently enrolled, list name as enrolled with MO HealthNet .

TYPE OR PRINT PROVIDER NAME ►

3. ENTER PROVIDER NPI ► _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

4. PROVIDER TAXONOMY CODE(S)► _____ _____ _____

SECTION B (Attach a voided check or letter from bank showing the routing and account numbers; routing number may not begin with 54)

1. ROUTING NUMBER	**2. DEPOSITOR ACCOUNT NUMBER**
— — — — — — — — —	— — — — — — — — — — — — — — — — —

3. TYPE OF BANK ACCOUNT (***checking/savings accounts only, check one***) ➡ ❑ CHECKING ❑ SAVINGS

4. FINANCIAL INSTITUTION NAME	**5. BRANCH NUMBER OR NAME** (if applicable)
6. FINANCIAL INSTITUTION ADDRESS	**7. TELEPHONE NUMBER** (include area code)

SECTION C

- I understand that in endorsing or depositing checks that payment will be from Federal and State funds and that any falsification, or concealment of material fact may be prosecuted under Federal and State laws.
- I hereby authorize the State of Missouri to initiate credit entries (deposits**)** and to initiate, if necessary, debit entries (withdrawals), or adjustments for any credit entries made in error to my account designated above.
- I understand that the State of Missouri may terminate my enrollment in the Direct Deposit program if the State is legally obligated to withhold part or all payments for any reason.
- I understand that the MO HealthNet Division may terminate my enrollment if I no longer meet the eligibility requirements.
- I understand that this document shall not constitute an amendment or assignment of any nature whatsoever, of any contract, purchase order, or obligation that I may have with an agency of the State of Missouri.

1. I hereby certify that I am an individual provider and below is my original signature (not a stamp or facsimile).

INDIVIDUAL PROVIDER ORIGINAL SIGNATURE►

2. NON-INDIVIDUAL PROVIDER TYPES SIGN HERE: I hereby certify that I am an authorized signer of this document, that I am an individual or representative of the Provider, and a duly authorized agent to execute this agreement on behalf of the Provider under authority granted by said Provider. I hereby certify that the signature below is my original signature (not a stamp or facsimile).

ORIGINAL SIGNATURE OF AUTHORIZED SIGNER►

TYPE OR PRINT NAME SIGNED ►

TITLE► **DATE SIGNED►**

TELEPHONE NUMBER► **EMAIL ADDRESS►**

RETURN ORIGINAL FORM BY MAIL ALONG WITH A VOIDED CHECK OR BANK LETTER TO:
MO HealthNet Division, Provider Enrollment Unit, PO Box 6500, Jefferson City MO 65102.
Provider Enrollment inquiries must be sent via e-mail to: providerenrollment@dss.mo.gov.

APPLICATION FOR PROVIDER DIRECT DEPOSIT INSTRUCTIONS
A SEPARATE FORM MUST BE COMPLETED FOR EACH NPI OR ATYPICAL IDENTIFIER ASSIGNED

SECTION A ***All sections must be completed***

1. **Type of Action** - Check appropriate box. If completing an application for enrollment and applying for direct deposit at the same time, or if the provider has never been enrolled in direct deposit, check the 'Provider Applicant' box.
2. **Provider Name -** Enter provider name as licensed, certified, or name listed with MO HealthNet if already enrolled.
3. **Provider NPI** - Enter the provider NPI. Currently enrolled providers who have been assigned an atypical identifier must enter the assigned identifier. A separate form must be completed for each NPI.
4. **Provider Taxonomy Code(s) –** If the provider uses one NPI for multiple MO HealthNet programs, enter each provider taxonomy code applicable to the direct deposit account listed on this form.

SECTION B

1. **Routing Number** - Enter your financial institution's routing number as printed on the bottom left portion of your business checks or deposit tickets (the first 9 digits). See Examples 1 and 2 below. **Routing numbers may not begin with 54**.

2. **Depositor Account Number** - Enter depositor account number as printed on the bottom of business checks following the routing number. It may be the first series of digits after the routing number followed by your check number (example 1) or it may be the series of digits which follow your check number (example 2). NOTE: The check number should not be included in the depositor account number.

To change routing or account - Complete and submit a new Application for Provider Direct Deposit with the changed information and forward to the **MO HealthNet Division**. Provider direct deposits will continue to be deposited into the designated account at your financial institution until the MO HealthNet Division is notified that you wish to change your account and/or financial institution.
DO NOT CLOSE AN OLD ACCOUNT UNTIL THE FIRST PAYMENT IS DEPOSITED INTO THE NEW ACCOUNT.

Example 1

FINANCIAL INSTITUTION CHECK NO.4444

HOMETOWN, USA

PAY TO ORDER OF _____

121456789 0087654109812 4444

↑ Routing No. ↑ Depositor Acct No. ↑ Check No.

Example 2

FINANCIAL INSTITUTION CHECK 4444

HOMETOWN, USA

PAY TO ORDER OF _____

121456789 4444 0087652109812

↑ Routing No. ↑ Check No. ↑ Depositor Acct No.

*********Credit Unions and Savings and Loan Associations may differ from the above examples. Please VERIFY your DEPOSITOR ACCOUNT NUMBER and ELECTRONIC ROUTING NUMBER with your financial institution.*********

SECTION C

1. **INDIVIDUAL PROVIDER SIGNATURE:** All direct deposit applications must be signed **with an original signature** by the enrolled/enrolling provider in the MO HealthNet program when that provider is an individual.
2. **NON INDIVIDUAL PROVIDER TYPES:** Applications on behalf of clinics, groups, businesses, or other entities must be signed **with an original signature** by the individual (officer) with fiscal responsibility for the group, business, entity, etc.

Signature stamp or other facsimile will not be accepted on this form.

ADDITIONAL INFORMATION

1. Attach a **voided check or a current letter from the bank** to validate the routing and account numbers listed on this form.
2. Direct deposit will be initiated after a properly completed Application for Provider Direct Deposit form is approved by the MO HealthNet Division and the successful processing of a test transaction through the banking system.
3. This form must also be used to change any financial institution information.
4. The MO HealthNet Division will terminate or suspend the direct deposit option for administrative or legal actions including, but not limited to, ownership change, duly executed liens or levies, legal judgments, notice of bankruptcy, administrative sanctions for the purpose of ensuring program compliance, death of a provider, and closure or abandonment of an account.
5. If any information completed on this form cannot be verified from the attachments or the form is completed incorrectly, the form(s) will be returned without being processed for direct deposit.
6. **This form must be submitted via mail; electronic submission of any kind will not be accepted.**