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

APPLICATION FOR PROVIDER DIRECT DEPOSIT

PLEASE TYPE OR PRINT IN BLACK INK ******SEE INSTRUCTIONS ON REVERSE SIDE******

SECTION A (All providers must complete this section)

1. TYPE OF ACTION

☐ NEW PROVIDER **OR** RE-ENROLLMENT ☐ CANCEL DIRECT DEPOSIT ☐ CHANGE ACCOUNT/ROUTE NUMBER(S)

2. PROVIDER NAME

Complete provider name below as shown on MO HealthNet provider records. **If the Application for Provider Direct Deposit is for a clinic or group**, this form must be accompanied by an Authorization by Clinic Members which **must** contain a list of the provider name(s) and provider identifier(s) of all individual providers employed at that clinic/group, along with the **ORIGINAL** Signature of the Clinic/Group owner or administrator. All other providers **MUST** complete a **separate** Application for Provider Direct Deposit containing their provider identifier and **original** signature. The clinic/group Application for Provider Direct Deposit will not be processed without the completed Authorization by Clinic Members. **A separate Application for Provider Direct Deposit must be completed by each provider identifier assigned, if other than an individual with a clinic/group.**

TYPE OR PRINT PROVIDER NAME HERE

3. PROVIDER IDENTIFIER (**ONE PROVIDER IDENTIFIER PER APPLICATION**)

___ ___ ___ ___ ___ ___ ___ ___ ___ ___

SECTION B (Complete this section if a new provider, re-enrollment, OR change in account/route number(s) is requested.) (A VOIDED CHECK SHOWING THE ROUTING AND ACCOUNT NUMBERS MUST BE ATTACHED FOR VERIFICATION)

1. ROUTING NUMBER	2. DEPOSITOR ACCOUNT NUMBER
___ ___ ___ ___ ___ ___ ___ ___ ___	___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

3. TYPE OF ACCOUNT **(MUST 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 wish to participate in Direct Deposit and in doing so:

- 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.

I am authorized to request Direct Deposit on behalf of this clinic/group and in doing so:

- I acknowledge that each individual in the clinic/group listed on the attached Authorization by Clinic Members has been informed of this request, and also informed that MO HealthNet funds will be sent to the depositor account specified above.
- I understand that each individual provider is responsible for all services provided and all billing done under the individual or clinic provider number, regardless to whom the reimbursement is paid. It is each individual provider's responsibility to use the proper billing code and indicate the length of time actually spent providing a service, regardless to whom the reimbursement is paid.

1. ☐ **I HEREBY CANCEL MY DIRECT DEPOSIT AUTHORIZATION,** and authorize future payments to be sent to the current payment name and address listed on the Provider Enrollment Master File. **(Section A, number 1 must also be completed)**

2. PROVIDER **ORIGINAL** SIGNATURE (SEE REQUIREMENTS ON REVERSE SIDE OF THIS FORM)	TYPE OR PRINT NAME SIGNED
3. DATE SIGNED	4. TELEPHONE NUMBER

SUBMIT THIS FORM (and original Authorization by Clinic Members, if applicable) **ALONG WITH A VOIDED CHECK OR LETTER FROM YOUR BANK TO:** MO HealthNet Division, Provider Enrollment Unit, PO Box 6500, Jefferson City, MO 65102. Provider Enrollment E-mail: providerenrollment@dss.mo.gov

APPLICATION FOR PROVIDER DIRECT DEPOSIT INSTRUCTIONS

SECTION A ***ALL PROVIDERS MUST COMPLETE THIS SECTION***

1. **Type of Action** - Check appropriate box. **If cancelling direct deposit you must also complete Section C, #1.**

2. & 3. **Provider Name and Provider Identifier** - Enter name **AND** identifier (if already enrolled).

SECTION B (THIS SECTION MUST BE COMPLETE FOR NEW APPLICANTS OR RE-ENROLLMENTS AND ANY CHANGES TO YOUR DIRECT DEPOSIT INFORMATION)

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.

Example 1

FINANCIAL INSTITUTION CHECK NO. 4444
HOMETOWN, USA

PAY TO THE ORDER OF ____________________

121456789 0087654109812 4444

Routing No. Depositor Acct. No. Check No.

Example 2

FINANCIAL INSTITUTION CHECK NO. 4444
HOMETOWN, USA

PAY TO THE 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. **TO CANCEL OR REDESIGNATE,** complete and submit a new Application for Provider Direct Deposit with the changed information and forward to the MO HealthNet Division. **You must check the CANCEL box if you wish to CANCEL your direct deposit, Section A number 1 must also be completed.** 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 **cancel or redesignate** your account and/or financial institution. **DO NOT CLOSE AN OLD ACCOUNT UNTIL THE FIRST PAYMENT IS DEPOSITED INTO YOUR NEW ACCOUNT.**
2. **PROVIDER SIGNATURE** - If the provider is enrolled as an individual, he/she must sign the form. Nursing homes, hospitals, independent laboratories and home health agencies must be signed by a person listed on form HCFA-1513 (disclosure of ownership) section III (a). If enrolled as a clinic or business (except those listed above) the form must be signed by the person with fiscal responsibility for the same. **Clinic applications must be accompanied by the Authorization by Clinic Members which must contain** a list of the name(s) and provider identifier(s) of all individual providers employed at that clinic/group location. **The Application for Provider Direct Deposit and the Authorization by Clinic Members MUST be signed by the same person. all other providers must complete** a separate Application for Provider Direct Deposit containing their individual provider identifier and their **original** signature. **A SEPARATE FORM MUST BE COMPLETED FOR EACH PROVIDER IDENTIFIER ASSIGNED.**

OTHER

1. **ATTACH A VOIDED CHECK to the back of this form.** This is necessary to verify your depositor account number, routing number and financial institution.
2. Direct deposit will be initiated after a properly completed application form is approved by the MO HealthNet Division and the successful processing of a test transaction through the banking system.
3. **This form must be used to change** any financial institution information or to cancel your election to participate in direct deposit.
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.