

**WHICH FORMS SHOULD I COMPLETE?**

- Electronic Funds Transfer (EFT) Enrollment/Modification Form (pages 2-3)
  - o **EFT enrollment must be completed in order to receive ERA**
- Electronic Remittance Advice Enrollment/Modification Form (pages 4-5)
- Additional instructions on completing these forms can be found at: [www.mass.gov/lists/eftera-enrollment](http://www.mass.gov/lists/eftera-enrollment)

**WHERE SHOULD I SEND THE FORM(S)?**

- Forms should be faxed or mailed with **ORIGINAL** signature in **BLUE** ink to:
  - o Fax: (617) 988-8974 or:
  - o Mail:  
MassHealth Provider Enrollment and Credentialing  
PO Box 278  
Quincy, MA, 02171-0278

**WHAT IS THE TURNAROUND TIME?**

- Standard processing time is 30 business days.

**HOW DO I CHECK STATUS?**

- To check the status of your enrollment, call MassHealth customer service at (800) 841-2900, TDD/TTY: 711.



## Electronic Funds Transfer (EFT) Enrollment/Modification Form

Complete this form to enroll in electronic funds transfer (EFT) with MassHealth or to terminate or modify an existing electronic funds agreement. Additional terms of agreement on page 2 of this form must be completed.

### PROVIDER INFORMATION

Provider Legal Name		DBA Name	
Street	City	State	Zip Code

### PROVIDER IDENTIFIERS INFORMATION

Provider TIN or EIN	NPI
---------------------	-----

### PROVIDER CONTACT INFORMATION

Provider Contact Name	
Telephone Number	Telephone Number Extension
E-mail Address	

### FEDERAL AGENCY INFORMATION

Federal Program Agency Identifier
-----------------------------------

### FINANCIAL INSTITUTION INFORMATION

Financial Institution Name			
Street	City	State	Zip Code
Financial Institution Routing Number		Type of Account at Financial Institution	
Provider's Account Number with Financial Institution			
Provider TIN	NPI		

### SUBMISSION INFORMATION

Reason for Submission	<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Change Enrollment	<input type="checkbox"/> Cancel Enrollment	Included	<input type="checkbox"/> Voided Check	<input type="checkbox"/> Bank Letter
Written Signature of Person Submitting Enrollment						
Printed Name of Person Submitting Enrollment					Submission Date	

If you are modifying or changing your bank account information, you must include your old bank account information on page 2 of this form or your request will be incomplete.

Please print double-sided whenever possible.

**Please complete page 2 in its entirety.**

If you are modifying your bank account information please provide the old bank account information directly below.

Provider Old Bank Account Number \_\_\_\_\_ Account Type  Checking  Savings

---

## **CERTIFICATION**

I, \_\_\_\_\_, hereby certify that the account(s) indicated on this form is under my direct control and access; therefore, I authorize the State Treasurer as fiscal agent for the Commonwealth of Massachusetts to initiate, change, or cancel credit entries to that account/s as indicated on this form. For ACH debits consistent with the International ACH Transaction (IAT) rules check one:

- I affirm that payments authorized hereunder are not to an account that is subject to being transferred to a foreign bank account.
- I affirm that payments authorized hereunder are to an account that is subject to being transferred to a foreign bank account.

This authority is to remain in full force and effect until the Office of Comptroller (CTR) has received written notification from either me or an authorized officer of the organization of the account's termination in such time and in such a manner as to afford CTR a reasonable opportunity to act upon it.

This authorization will remain in effect until it is canceled in writing or until an updated form changing information is sent to the department you currently do business with.

**Signature of authorized representative** \_\_\_\_\_

---

- Please contact your financial institution to arrange for the delivery of the CORE (Committee on Operating Rules for Information Exchange)-required Minimum CCD+(Corporate Credit or Debit entry) data elements needed for reassociation of the payment and the Electronic Remittance Advice (ERA).
- Instructions to complete the EFT Enrollment/Modification form can be found at [www.mass.gov/eohhs/docs/masshealth/aca/eft-instructions.pdf](http://www.mass.gov/eohhs/docs/masshealth/aca/eft-instructions.pdf). You may also confirm the status of your EFT enrollment by contacting the MassHealth Customer Services Center at 1-800-841-2900.
- The EFT user job aid that explains how providers may match the EFT payment to the remittance advice can be found at <https://massfinance.state.ma.us/VendorWeb/MassHealthProviderJA.asp>.
- The EFT Enrollment/Modification form can be completed manually or electronically. Electronic submissions must be printed, signed, and mailed to the address below. The Commonwealth of Massachusetts requires a "wet" signature on all EFT enrollments, modifications, and terminations. All paper forms must be mailed to the following address.

**MassHealth Customer Services Center**  
**Attn: Provider Enrollment and Credentialing**  
**P.O. Box 9162**  
**Canton, MA 02021-5213**



## Electronic Remittance Advice Enrollment/Modification Form

### PROVIDER INFORMATION

Provider Legal Name		DBA Name	
Street	City	State	Zip Code

### PROVIDER IDENTIFIERS INFORMATION

Provider TIN or EIN	NPI
---------------------	-----

### Other Identifier(s)

Assigning Authority	Trading Partner ID
Provider Type	Provider Taxonomy Code

### PROVIDER CONTACT INFORMATION

Provider Contact Name		Title	
Telephone Number	Telephone Number Extension	Fax Number	
E-mail Address			

### PROVIDER AGENT INFORMATION

Provider Agent Name			
Street	City	State	Zip Code
Provider Agent Contact Name		Title	
Telephone Number		Telephone Number Extension	
E-mail Address		Fax Number	

### RETAIL PHARMACY INFORMATION

Pharmacy Name		
Chain Number	Parent Organization ID	Payment Center ID
NCPDP Provider ID Number	Medicaid Provider Number	

### ELECTRONIC REMITTANCE ADVICE INFORMATION

Provider Tax ID	Provider NPI	Method of Retrieval
-----------------	--------------	---------------------

**ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION**

Clearinghouse Name

Clearinghouse Contact Name

Telephone number

E-mail Address

**ELECTRONIC REMITTANCE ADVICE VENDOR INFORMATION**

Vendor Name

Vendor Contact Name

Telephone Number

E-mail Address

**SUBMISSION INFORMATION**Reason for Submission:  New Enrollment  Change Enrollment  Cancel Enrollment

Written Signature of Person Submitting Enrollment

Printed Name of Person Submitting Enrollment

Printed Title of Person Submitting Enrollment

Submission Date

Requested ERA Effective Date

- Instructions to complete the ERA Enrollment/Modification form can be found at [www.mass.gov/eohhs/docs/masshealth/aca/era-instructions.pdf](http://www.mass.gov/eohhs/docs/masshealth/aca/era-instructions.pdf).  
You may also confirm the status of your ERA enrollment by contacting MassHealth Customer Service at 1-800-841-2900.
- The ERA Enrollment/Modification form can be completed manually or electronically via the Provider Online Service Center (POSC). All paper forms must be mailed to the following address:

**MassHealth Customer Service**  
**Attn: Provider Enrollment and Credentialing**  
**P.O. Box 9162**  
**Canton, MA 02021**