



ELECTRONIC FUNDS TRANSFER (EFT) For Provider Payments

Gold Coast Health Plan is pleased to announce the availability of Electronic Funds Transfer (EFT). Providers who enroll in EFT will have their Medi-Cal payments deposited directly into their checking or savings account. The EFT option is available to in-network providers in Ventura County.

To enroll in EFT, providers must complete the **EFT PROVIDER ENROLLMENT FORM** that can be found at the end of this document. Prior to completing the form, please read the INSTRUCTION SHEET carefully and follow the directions.

Providers with more than one National Provider ID (NPI) should attach a list of NPI numbers to the application. Please note that any attachments to the EFT application must have original signatures.

Provider Groups that receive payments under the Group ID need only to complete a single enrollment form for the Group NPI. However, members of Provider Groups who also bill individually may enroll by submitting a separate enrollment form using their individual Provider NPI.

ONE of the following items must be attached to your enrollment form:

- A voided check from your checking account.
- If you have a deposit-only checking account (and do not have checks) or you choose to have the EFT deposited into a savings account, you may submit a letter from a bank officer verifying your account information. The letter must be on bank letterhead and include the bank's name, address and routing number, the type of account, the account number, and the account owner's name, address and tax ID number. The letter also must be signed by a bank officer and notarized.

EFT enrollment applications that do not conform to these instructions will be rejected.

After sending the EFT PROVIDER ENROLLMENT FORM to GCHP, please allow a minimum of 6 to 8 weeks for processing.

The EFT transactions will be initiated on Wednesdays. But due to normal banking procedures, the transferred funds may not be available for up to 7 days after the transfer. Please contact your banking institution regarding the availability of your funds.

If you have any questions about the EFT process, please call GCHP Customer Service at 1-888-301-1228.

INSTRUCTIONS FOR ELECTRONIC FUNDS TRANSFER (EFT) ENROLLMENT

Providers wishing to request EFT of GCHP Medi-Cal funds must complete an EFT Provider Enrollment Form and mail it along with a blank check from the checking account to which the funds are to be transferred. The check must contain the name and address of the provider or provider organization and the word "VOID" must be written across its face.

OR

If you have a deposit-only checking account (and you do not have checks) or you choose to have the EFT deposited into a savings account, you may submit a letter from a bank officer. The letter must be on bank letterhead and include the bank's

name, address and routing number, the type of account, the account number, and the account owner's name, address and tax ID number. The letter also must be signed by a bank officer and notarized.

Sections A and B of the EFT form must be complete and legible, otherwise, the request will not be processed and will be returned.

Section A: Provider Information

Step 1 – Enter the Provider's Name: Complete legal name of institution, corporate entity, practice or individual provider as it is filed with GCHP.

Step 2 – Enter the Provider Identifier National Provider ID (NPI) (or group NPI if payment is made to a group practice).

- Providers with more than one NPI, attach a list of NPI numbers to the application. **Provider Groups that receive payments under the Group number need only to complete a single enrollment form for the Group NPI.** However, members of Provider Groups who also bill individually may enroll by submitting a separate enrollment form using their individual provider number

Step 3 – Enter the Doing Business As (DBA) name: A legal term used in the U.S. meaning a trade name, or fictitious business name, under which the business or operation is conducted and presented to the world is not the legal name of the legal person (or persons) who actually own it and are responsible for it.

Step 4 – Enter the Provider Identifier Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN).

Step 5 – Enter the **Provider Contact Name**: Name of contact in provider office for handling EFT issues.

Step 6 – Enter **Telephone**: Associated with contact person.

Step 7 – Enter **Email Address**: An electronic mail address in which the health plan might contact the provider.

Step 8 – Enter **Provider Address**: The number and street name where a person or organization can be found, City, State and Zip Code.

Step 9 – Enter **Provider Agent Name**: Name of provider's authorized agent.

Step 10 – Enter **Provider Agent's Telephone Number**.

Step 11 – Enter the **Provider Agent's Address**.

Step 12 – Enter the **GCHP Provider ID Number** (it must match the number registered with GCHP).

Step 13 – Enter **Provider Agent Email Address**.

Section B: Banking Information

Step 1 – Enter the **Financial Institution Routing Number**: A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited. Numbers can be found at the bottom of your check.

Step 2 – Enter the **Provider's Account Number** with Financial Institution: Provider's account number at the financial institution to which EFT payments are to be deposited.

Step 3 – Type of **Account at Financial Institution**: The type of account the provider will use to receive EFT payments, e.g. Checking, Saving.

Step 4 – **Financial Institution Name**: Official name of the Provider's financial institution.

Step 5 – **Financial Institution Address**: Street Address associated with receiving depository financial institution name field, City, State, Zip Code.

Section C: EFT Authorization or Cancellation

Providers should complete and sign this section. All documents received will be processed and placed in the provider's file. Please note: For providers who have claims paid within a particular payment cycle, Medi-Cal funds are normally scheduled to be transferred on Wednesday afternoons. Due to normal banking procedures, the funds may not become available in the provider's account for up to 48 hours from the initial transfer. Please contact your banking institution with questions about the availability of funds.

Please allow a minimum of 6 to 8 weeks for your request to be processed.

To change banking information, providers must send the following:

- A new EFT enrollment form indicating the new banking information. The enrollment form must be signed with an original signature and a title must be indicated.
- A voided check with the new account and routing numbers must be attached to the new enrollment form. If the account is a "deposit only" account, attach a signed, notarized letter from your banking institution indicating the new account and routing numbers. Regardless of what is being updated, both the account and routing numbers must always be indicated.
- A letter indicating changes to your account is required. The letter must be on company letterhead and include any provider number(s) (tax ID and NPI), new account and routing numbers and a brief explanation for the change. The letter must have an original signature and a title should be indicated.

Note: If you are changing your EFT from one banking institution to another banking institution, your payments will automatically transfer back to paper for a two week time frame while your EFT is being set up on your new account.

To cancel EFT transactions, providers must send an EFT authorization form, including the provider number(s), applicable Tax ID and/or NPIs, to the address below. Please allow 6 to 8 weeks to transition to a paper check.



Email or Mail the completed form with the voided check and attachments (if applicable) to:

Email: ProviderRelations@goldchp.org
ATTN: GCHP EFT (DBA/Provider name)

OR

Mail: Gold Coast Health Plan, Attention: EFT Processing - Provider Relations Dept.
P.O. Box 9153, Oxnard, CA 93031

Questions about form completion should be directed to GCHP Customer Service at 1-888-301-1228.

ELECTRONIC FUND TRANSFER AUTHORIZATION

Gold Coast Health Plan: This authorization remains in full force and effect until GCHP receives written notification from the provider of its termination, or until GCHP or an appointing authority deems it necessary to terminate the agreement.

DIRECTIONS: An original pre-imprinted voided check for checking accounts, or an original bank letter for savings accounts, must be submitted with this form. The provider name, routing number and account number on either of those documents must match what is entered on this form. Photocopied documents will not be accepted. *Use blue ink for signatures, including notary.*

SECTION A: PLEASE PRINT OR TYPE

1. NAME OF PROVIDER (must match name on bank account and name registered with GCHP)		2. PROVIDER IDENTIFIER NPI NUMBER (one EFT form per number)	
3. DOING BUSINESS AS NAME (DBA)		4. PROVIDER IDENTIFIER (TIN OR EIN)	
5. PROVIDER CONTACT NAME	6. TELEPHONE PHONE NUMBER	7. EMAIL ADDRESS	
8. PROVIDER ADDRESS		City	State Zip Code
9. PROVIDER AGENT NAME (Name of provider's authorized agent)		10. PROVIDER AGENT TELEPHONE NUMBER	
11. PROVIDER AGENT ADDRESS		City	State Zip Code
12. GCHP PROVIDER ID NUMBER (must match number registered with GCHP)		13. PROVIDER AGENT EMAIL ADDRESS	

SECTION B

1. FINANCIAL INSTITUTION ROUTING NUMBER	2. PROVIDER'S ACCOUNT NUMBER (include leading zeros)	3. TYPE OF ACCOUNT AT FINANCIAL INSTITUTION <input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS	
4. FINANCIAL INSTITUTION NAME			
5. FINANCIAL INSTITUTION ADDRESS		City	State Zip Code



SECTION C (Check the appropriate box)

- I hereby authorize Gold Coast Health Plan to initiate credit entries to my bank account as indicated above, and the depository named above to credit the same to such account. For changes to existing accounts, do not close an existing account until the first payment has been deposited into the new account.
- I hereby **CANCEL** my EFT authorization.

I understand that by signing this form, payments issued 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.

Authorized Signature: _____ Date: _____
(PRINT the form, sign it in **BLUE INK ONLY** (must be owner or corporate officer), and send it via mail or email.)

Mail This Form To:

Gold Coast Health Plan
ATTN: EFT Processing - Provider Relations Dept.
P.O. Box 9153
Oxnard, CA 93031

Email Only:

ATTN: GCHP EFT [DBA/PROVIDER NAME]
ProviderRelations@goldchp.org

Privacy Statement (Civil Code Section 1798 et seq.): The information requested on this form is required by Gold Coast Health Plan for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your request being delayed or not processed.