State of California
Health and Human Services Agency

Department of Health Care Services

Electronic Funds Transfer (EFT)

Enrolled User Enrollment Form

Section I- General Information (Refer to the instructions on page 2)

A. Program Name:	**B.** DHCS Account:
C. Beneficiary/ Provider/ Attorney/ Case Name:	
D. Mailing Address: (Number, Street, City, State, Zip code)	
E. Email Address: (Review for accuracy)	Re-type Email Address:
F. Payment Contact Person: (Required for Providers and Law Offices)	**G.** Phone Number: (xxx) xxx-xxxx

Notice: This document is for DHCS internal use only and will not be shared with other entities.
Information provided in this section will only be used for account validation and enrollment in the EFT Enrolled User option by DHCS staff and its authorized financial institution.
By providing your email address you agree to receive and accept communications regarding EFT via email.

Section II- Authorization

Please read the following Authorization Agreement:

Automated Clearing House (ACH) Debit- I hereby authorize designated Financial Agents of the Department of Health Care Services (DHCS), Third Party Liability and Recovery Division (TPLRD) to initiate debit entries to the financial institution account that I saved in my Enrolled User Account, for payments owed to the DHCS/TPLRD upon my request (beneficiary/ provider) or my representative, using ACH debit method.

- I authorize the disclosure of my individually identifiable information as described above for the purpose described.
- If I sign this authorization to use or disclose information, I can revoke that authorization at any time, in writing. The revocation will not affect information already used or disclosed.
- I have the right to receive a copy of this enrollment form.
- I am signing this authorization voluntarily. Treatment, payment or my eligibility for benefits will not be affected if I do not sign this authorization.
- I understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.
- I agree to receive EFT account correspondence via the contact information that I provided on this form.
- I hereby certify that the information given by me in this EFT Enrollment Form is true and correct.
- I understand and agree that any false information or misrepresentation of facts may be a justification for refusal of enrollment to the EFT Enrolled User option.

A. Beneficiary/ Provider Representative/ Contact Signature	**B. Date**

Instructions:

Section I - General Information (All information is required, except F.)

A. Program Name: Select a program from the drop down menu for the type of payment that you will make.

B. DHCS Account:

- For Beneficiaries, enter your Client Index Number (CIN), and DHCS will provide you with the complete DHCS Account to use.
- For Law Offices, this will be assigned by DHCS. Leave this field blank.
- For Providers, enter your National Provider Identifier (NPI) or Client Index Number (CIN), and DHCS will provide you with the complete DHCS Account to use.

C. Beneficiary/ Provider/ Attorney/ Case Name: Enter the complete Medi-Cal Beneficiary or Provider Name as shown on DHCS invoice or correspondence. For Attorneys, enter your business name. For Estate Recovery, enter the Estate or Case Name.

D. Mailing Address: Enter your mailing address where DHCS correspondence and forms should be sent. For verification purposes, this information should match your records with the Medi-Cal program.

E. Email Address: Enter your email address and re-enter to make sure that it is correct.

F. Payment Contact Person: If different from the Beneficiary Name, enter name of the authorized personal representative of the beneficiary, or the name of the contact person for a Provider, Business, or Estate. This is required for Providers and Law Offices.

- If you are an authorized personal representative for a beneficiary (e.g. legal guardian, conservator, etc.), please provide proof of authority to sign on behalf of the beneficiary (e.g. letters of conservancy, court order, etc.)

G. Phone Number: Enter the phone number that DHCS can contact you regarding your EFT account.

Section II - Authorization – This section must be completed.

A. Signature: The beneficiary, attorney, or the provider's contact person must sign the form to indicate participation in the EFT Enrolled User option and agreement with the terms and conditions.

B. Date: Enter the date the form is signed.

Send the completed enrollment form by mailing to:

Department of Health Care Services
TPLRD ASU EFT Admin, MS 4718
P.O. Box 997425
Sacramento, CA 95899-7425

By enrolling in the Enrolled User option, payments are not automatically deducted from your bank account. Enrolled Users are responsible for logging in and scheduling payments to DHCS.

Allow up to 5 business days for processing. DHCS will email you a security code and mail you a letter confirming your DHCS Account after your enrollment has been processed.

Enrolled User option is recommended for payers that need to make monthly payments and want to view payment history. It is also recommended for payers such as attorneys or providers who may need to make payments for multiple accounts/cases.

For help in completing this form and for detailed information regarding EFT, please refer to the documents under Quick Reference Links located at http://dhcs.ca.gov/epay.