ForwardHealth Portal Electronic Funds Transfer

March 11, 2024



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1 Introduction

This user guide provides general instructions on how to enroll in and administer a ForwardHealth electronic funds transfer (EFT) account.

1.1 Important Information

The following information should be reviewed and understood prior to enrolling for EFT payments from ForwardHealth:

- All EFT enrollments must be completed via your secure Provider Portal account. Paper enrollments will not be accepted.
- Only a clerk who has been assigned the EFT role may enroll in EFT. An account administrator may create a new clerk account for this purpose or may modify an existing clerk account to have an EFT role.
- Once enrolled for EFT, organizations cannot revert back to receiving paper checks.
- Organizations may change their EFT information at any time.
- Enrolling in EFT does not change your Remittance Advice. You will continue to receive your remittance information the same way.

If you do not have a ForwardHealth Portal account and wish to enroll in EFT, go to <u>https://www.forwardhealth.wi.gov/</u> to request a ForwardHealth Portal account. You may also call the ForwardHealth Portal Helpdesk at 866-908-1363 for assistance in requesting a Provider Portal account.

1.2 Getting Started

All administrative accounts have access to the EFT enrollment and tracking function on the ForwardHealth Portal.

Account administrators who wish to delegate EFT enrollment and tracking functionality to users within their organization can create clerk accounts, modify existing clerk accounts, and grant those clerk accounts access to the EFT enrollment and tracking functionality. The EFT role should only be assigned to those clerks who need access to EFT information and should be removed when no longer needed.

Note: Please be advised that EFT information includes data about your financial institution and EFT settlement account number. By granting a clerk the EFT role, account administrators are granting clerks access to this information. Account administrators are responsible for ensuring that access to this information is restricted to only those clerks authorized within the organization to view the information.

For information about managing clerk accounts, refer to the "Clerk Maintenance" section of the <u>ForwardHealth Provider Portal Account User Guide</u> which is located on the Portal User Guides page of the ForwardHealth Portal.

2 Enroll in Electronic Funds Transfer

1. Access the ForwardHealth Portal at https://www.forwardhealth.wi.gov/.

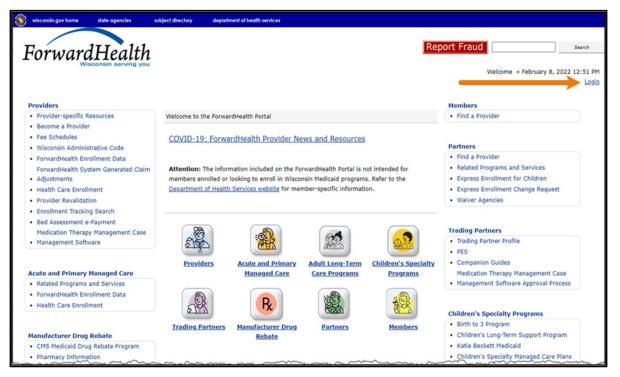


Figure 1 ForwardHealth Portal Page

2. Click Login. A Sign In box will be displayed.

	ForwardHealth	
	Sign In	
User	name	
Пĸ	eep me signed in	
	Next	
Unlo	ck account?	
Help		
Logg	ng in for the first time?	

Figure 2 Sign In Box

- 3. Enter the user's username.
- 4. Click **Next**. A Verify with your password box will be displayed.

ForwardHea	lth
Verify with your pa	
Password	
•••••	•
Verify	
Forgot password?	
Back to sign in	

Figure 3 Verify With Your Password Box

5. Enter the user's password.

6. Click Verify. The Secure Provider page will be displayed.

visconsin.gov home state agencles subject directory department of health services	
ForwardHealth Visconsin serving you	Welcome Inpatient03 UAT » May 7, 2019 2:35 Pl Logor
Iome Search Providers Enrollment Claims Prior Authorization Remittance Advices Trade File Account Contact Information Online Handbooks Site Map User Guides Certification	es Health Check Max Fee Home
ou are logged in with NPI: 1255334173, Taxonomy Number: 282N00000X, Zip Code: 53226, Financial ayer: Medicaid Providers	Search
What's New?	Home Page
What's New? Providers can improve efficiency while reducing overhead and paperwork by using real-time applications available on the new ForwardHealth Portal. Submission and tracking of claims and prior authorization requests and amendments, on-demand access to remittance information, 835 trading partner designation, and instant access to the most current ForwardHealth information is now available.	Home Page Update User Account Customize Home Page Demographic Maintenance Electronic Funds Transfer Check My Revalidation Date Revalidate Your Provider Enrollment Check Enrollment
Providers can improve efficiency while reducing overhead and paperwork by using real-time applications available on the new ForwardHealth Portal. Submission and tracking of claims and prior authorization requests and amendments, on-demand access to remittance information, 835 trading partner designation,	Update User Account Customize Home Page Demographic Maintenance Electronic Funds Transfer Check My Revalidation Date Revalidate Your Provider Enrollment
Providers can improve efficiency while reducing overhead and paperwork by using real-time applications available on the new ForwardHealth Portal. Submission and tracking of claims and prior authorization requests and amendments, on-demand access to remittance information, 835 trading partner designation, and instant access to the most current ForwardHealth information is now available.	Update User Account Customize Home Page Demographic Maintenance Electronic Funds Transfer Check My Revalidation Date Revalidate Your Provider Enrollment
 available on the new ForwardHealth Portal. Submission and tracking of claims and prior authorization requests and amendments, on-demand access to remittance information, 835 trading partner designation, and instant access to the most current ForwardHealth information is now available. New Rate Reform Part 3 Ideas/Recommendations Requested. 	Update User Account Customize Home Page Demographic Maintenance Electronic Funds Transfer Check My Revalidation Date Revalidate Your Provider Enrollment

Figure 4 Secure Provider Page

7. Click **Electronic Funds Transfer** located in the Home Page box on the right of the page. The Introduction page will be displayed.

Note: Electronic funds transfer enrollment must be initiated by an account administrator or clerk who has been assigned the EFT role. Clerks not assigned the EFT role will not see the EFT link. Account administrators who wish to delegate the EFT enrollment and tracking functionality to other users within their organization can create clerk accounts, modify existing clerk accounts, and grant those clerk accounts access to the EFT enrollment and tracking functionality. For information on adding a role to a clerk, refer to the ForwardHealth Provider Portal Account User Guide.

Introduction
Required fields are indicated with an asterisk (*).
For New EFT enrollments or Changes to Existing EFT Enrollments:
You will need to have the following information available:
 The name and email address for the person in your organization that will serve as the contact for al EFT information.
 The financial institution's ABA routing number. The account number and the name on record with the bank/financial institution as the Account Holder for the account.
 The type of account (savings or checking, personal or business).
Existing EFT Data
 Any existing EFT information will be pre-populated based on the current organization you are logged in with.
To Check the Status of Your EFT Enrollment:
 Click "Next" below and a status screen will appear.
User Guide
• <u>View</u> the EFT user guide.
EFT Processing Overview
<u>View</u> the EFT processing overview.
Next Exit C

Figure 5 Introduction Page

8. Gather the information listed on the Introduction page. Your financial institution's American Bankers Association (ABA) routing number and the account number used for your EFT transactions can be found on the account's checks and deposit slips.

	Account Number
The start of the st	0000000 1001
OP AN TO THE	
-	DOLLARS & REFE
YOUR FINANCIAL INSTI	UTION
1123456780	234,56* 1001
	9-digit ABA Bank Routing Number

Figure 6 Sample Check

9. Click **Next**. The Electronic Funds Transfer Request page will be displayed.

Organization List ZIP ZIP + 4 Taxonomy Provider Type Payer 000000001 LADYSMITH WI 54848 000N0000X Physician Group Medicaid 0000000002 PLATTEVILLE WI 53818 1264 100N0000X Hospital Medicaid 0000000003 COTTAGE GROVE WI 53527 200N00000X Pharmacy Medicaid 0000000004 MIDDLETON WI 53562 300N0000X Dentist Medicaid 0000000006 LADYSMITH WI 54848 400N0000X Physician Group Medicaid 0000000006 GREEN BAY WI 54305 500N0000X Hospital Wisconsin Chr		
0000000001 LADYSMITH WI 54848 000N00000X Physician Group Medicaid 0000000002 PLATTEVILLE WI 5818 1264 100N0000X Hospital Medicaid 0000000000 COTTAGE GROVE WI 53527 200N0000X Pharmacy Medicaid 0000000004 MIDDLETON WI 5352 300N0000X Pharita Medicaid 0000000004 MIDDLETON WI 53562 300N0000X Physician Group Medicaid 0000000005 LADYSMITH WI 54848 400N0000X Physician Group Medicaid	No EFT on file 🔲 View History	
0000000002 PLATTEVILLE WI 53818 1264 100N00000X Hospital Medicaid 0000000003 COTTAGE GROVE WI 53527 200N00000X Pharmacy Medicaid 0000000004 MIDDLETON WI 53522 300N00000X Dentist Medicaid 0000000005 LADYSMITH WI 54848 400N00000X Physician Group Medicaid		
000000003 COTTAGE GROVE WI 53527 200N00000X Pharmacy Medicaid 0000000004 MIDDLETON WI 53562 300N00000X Dentist Medicaid 0000000005 LADYSMITH WI 54848 400N00000X Physician Group Medicaid		r
0000000004 MIDDLETON WI 53552 300N00000X Dentist Medicaid 0000000005 LADYSMITH WI 54848 400N00000X Physician Group Medicaid	No EFT on file 📃 View History	r
0000000005 LADYSMITH WI 54848 400N00000X Physician Group Medicaid	Active View History	r
	Active View History	,
000000006 GREEN BAY WI 54305 500N00000X Hospital Wisconsin Chr	No EFT on file 📃 View History	r
	n Chronic Disease No EFT on file 📃 View History	,
		Select All M

Figure 7 Electronic Funds Transfer Request Page

If you are an EFT clerk, this page will display all the service locations for which you are assigned the EFT role. Account administrators will see all the service locations for the provider under which they are logged in.

The EFT Status column displays the current status of each service location. Service locations not yet enrolled in EFT will display a status of *No EFT on file*.

10. Check the Add/Change box for each service location that is to be enrolled in EFT. If all the service locations listed are to be enrolled, click Select All.

Note: When more than one service location is selected, all the information entered in the succeeding pages will apply to all the service locations selected. If there is a difference in the EFT set-up information used between service locations, including demographic information, email addresses, ABA routing numbers, EFT settlement account numbers, and account types, the service locations must be entered separately.

11. Click **Next**. The General Information page will be displayed.

General Information		9
Required fields are indicated with	an asterisk (*).	
 <u>View the EFT User Guide</u> If you need to change the 	tax information below, please go to the <u>Demographic Maintenance Tool</u> to submit your new information through the portal.	
Pay To Address		
Name - Business or Individual	STATE UNIVERSITY	
Street Address Line 1	123 MAIN STREET	
Street Address Line 2	MEDICAL FOUNDATION	
City	ANYTOWN	
State/ZIP	WI 🗸 55555 -	
Contact Information Name - Contact Person* Primary E-mail Address* Telephone Number* Fax Number Other EFT Contact Notificat E-mail Address 1 E-mail Address 2 E-mail Address 3	ion Addresses	
E-mail Address 4		
Tax Identification Informatio	on	
Taxpayer Identification Numbe	r (TIN) 00000000	
Name - FEI	IN/SSN IM A. PROVIDER	
	Previous Next	Exit

Figure 8 General Information Page

The "Pay To Address" and "Tax Identification Information" sections are pre-filled with the information you already have on file.

Note: If it is necessary to change the tax identification information, click **Demographic Maintenance Tool** located at the top of the page to submit your new information.

12. In the "Contact Information" section, enter the name and contact information of the individual from your organization designated as the primary contact for all notices and information regarding EFT. The email address entered in the "Contact Information" section will serve as the primary email contact for the EFT account.

Name - Contact Person*	JANE DOE	
Primary E-mail Address*	jane.doe@abc.com	
Telephone Number*	(123)456-7800 Ext.	
Fax Number	(123)456-7801	
Other EFT Contact Not		
Other EFT Contact Not E-mail Address 1 john.s	tification Addresses	
	tification Addresses	
E-mail Address 1 john.s	tification Addresses	

Figure 9 Contact Information and Other EFT Contact Notification Addresses Sections

- 13. In the "Other EFT Contact Notification Addresses" section, add email addresses for any other individuals who should be notified of changes or issues with the EFT account.
- 14. Click Next. The Financial Institution Information page will be displayed.

Financial Institution Inform	ation		9
Required fields are indicated w	ith an asterisk (*).		
• <u>View</u> the EFT user guide	2.		
Search Criteria			
ABA Routing Number			
Financial Institution Name			
			Search <u>*</u>
Search Results			
Financial Institutions *** No rows found *	**	_	
No rows round			
\sim Selected Financial Institut	ion		
	ion		
ABA Routing Number			
Financial Institution Name			
Address Line 1			
Address Line 2			
City			
State/ZIP	-		
Telephone Number	Ext.		
L			
	Previous	<u>N</u> ext	Exit <u>C</u>

Figure 10 Financial Institution Information Page

- 15. In the "Search Criteria" section, enter either the ABA routing number or the name of the financial institution you wish to use for settlement of the ForwardHealth EFT payments.
- 16. Click **Search**. A list of the available financial institutions matching your search criteria will be displayed in the "Search Results" section.

Financial Institution Inform	ation					9
Required fields are indicated w	ith an asterisk (*).					
• <u>View</u> the EFT user guide	3.					
Search Criteria						
ABA Routing Number	070707070					
Financial Institution Name						
					Search *	
Search Results						
Financial Institutions						
ABA Number Name 070707070 GENERAL BAN	K GREEN BAY, N.A.	Address Line 1	City GREEN BAY	<u>State</u> WI	ZIP ZIP+4	
	man	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	~~~	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	\sim

Figure 11 Search Results Section

17. From the displayed list, click the financial institution whose information matches the ABA routing number, name, and address of the institution with which your organization has an account and that your organization wishes to designate as their ForwardHealth EFT financial institution. Information for the selected financial institution will be displayed in the "Selected Financial Institution" section.

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	~~~~	Land and the second	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	
Celected Financial Ins	titution -					
ABA Routing Num	ber 070	707070				
Financial Institution Na	me GEN	ERAL BANK G	REEN BAY, I	N.A.		
Address Lin	e 1					
Address Lin	e 2					
	City GRE	EN BAY				
State/	ZIP WI		-			
Telephone Num	ber		Ext.			
ι,		Previous	<u>N</u> ext			Exit C

Figure 12 Selected Financial Institution Section

- 18. Verify that the populated information is correct.
- 19. Click Next. The Account Information page will be displayed.

Account Information		?
Required fields are indicated with	an asterisk (*).	
• <u>View</u> the EFT user guide.		
Account Information		
Customer Account Number*		
	C Checking C Savings	
Business or Personal Account*	Business C Personal	
Account Holder Information		
Name - Account Holder*		
Street Address Line 1*		
Street Address Line 2		
City*		
State/ZIP* WI	▼	
Telephone Number*	Ext.	
	Previous Next Exit	

Figure 13 Account Information Page

- 20. Enter information in and select information for the fields in the "Account Information" and "Account Holder Information" sections.
- 21. Click **Next**. The Authorization to Make Electronic Fund Payments page will be displayed.

<ul> <li>squired fields are indicated with an asterisk (*).</li> <li>View the EFT user guide.</li> <li>Authorization On behalf of the health care provider identified above, by my signature below I hereby represent as follows: <ol> <li>I authorize the Department of Health Services (DHS) to deposit, by electronic funds transfer, payments owed to the provider by the State of Wisconsin and, if necessary, initiate debit adjustments for any electronic deposits made in error to the account indicated above. I hereby authorize the financial institution/bank named above to credit and/or debit the same to such account.</li> <li>I acknowledge that funds deposited pursuant to this authorization are payments by the State of Wisconsin and are subject to the same laws, rules and policies as payments made in any other manner.</li> <li>I acknowledge that if the provider fails to provide complete or accurate information on this authorization form, the processing of the form may be delayed or my payments may be erroneously transferred electronically. In the event that due to failure to provide complete or accurate information OHS deposits payments into an account over which the provider does not have control, I agree that DHS shall be held harnless for such payments. </li> <li>I acknowledge that any information provided in this document constitutes a statement or representation of a material fact knowledge that any information is effective as of the signature date below and will remain in full force and effect until the DHS has received written notification from an authorized representative of provider at least this authorization. The DHS will continue to send the direct deposit is termination. The DHS will continue to send the direct deposit to the financial institution indicated above until notified in accordance with the bar anydated EFT Authorization effort wishes to change the framcal institution any and all arrangements.</li> <li>I acknowledge that this authorization is effective as of the signature date below and</li></ol></li></ul>
<ul> <li>Authorization</li> <li>On behalf of the health care provider identified above, by my signature below I hereby represent as follows: <ol> <li>I authorize the Department of Health Services (DHS) to deposit, by electronic funds transfer, payments owed to the provider by the State of Wisconsin and, if necessary, initiate debit adjustments for any electronic deposits made in error to the account indicated above. I hereby authorize the financial institution/bank named above to credit and/or debit the same to such account.</li> <li>I acknowledge that funds deposited pursuant to this authorization are payments by the State of Wisconsin and are subject to the same laws, rules and policies as payments made in any other manner.</li> <li>I acknowledge that if the provider fails to provide complete and accurate information on this authorization form, the processing of the form may be delayed or my payments may be erroneously transferred electronically. In the event that due to failure to provide complete or accurate information DHS deposits payments into an account over which the provider does not have control, I agree that DHS shall be held harmless for such payments.</li> <li>I hereby certify that the provider has control of the account referenced above, and that the financial institution and all arrangements between the financial institution and the provider are in compliance with all applicable federal and Automated Clearing House (ACH) regulations and instructions.</li> <li>I acknowledge that any information provided in this document constitutes a statement or representation of a material fact knowingly and willfully made or caused to be made for use in determining rights to payment within the meaning of s.49.49(1) and (4m), Wis. Stats., and that if any such information is false, criminal or other panalties may be imposed under those laws.</li> </ol> </li> <li>I acknowledge that this authorization is effective as of the signature date below and will remain in full force and effect until the DHS has received wr</li></ul>
<ul> <li>Authorization</li> <li>On behalf of the health care provider identified above, by my signature below I hereby represent as follows: <ol> <li>I authorize the Department of Health Services (DHS) to deposit, by electronic funds transfer, payments owed to the provider by the State of Wisconsin and, if necessary, initiate debit adjustments for any electronic deposits made in error to the account indicated above. I hereby authorize the financial institution/bank named above to credit and/or debit the same to such account.</li> <li>I acknowledge that funds deposited pursuant to this authorization are payments by the State of Wisconsin and are subject to the same laws, rules and policies as payments made in any other manner.</li> <li>I acknowledge that if the provider fails to provide complete and accurate information on this authorization form, the processing of the form may be delayed or my payments may be erroneously transferred electronically. In the event that due to failure to provide complete or accurate information DHS deposits payments into an account over which the provider does not have control, I agree that DHS shall be held harmless for such payments.</li> <li>I hereby certify that the provider has control of the account referenced above, and that the financial institution and all arrangements between the financial institutions and instructions.</li> <li>I acknowledge that any information provided in this document constitutes a statement or representation of a material fact knowingly and willfully made or caused to be made for use in determining rights to payment within the meaning of s.49.49(1) and (4m), Wis. Stats., and that if any such information is false, criminal or other penalties may be imposed under those laws.</li> <li>I acknowledge that this authorization is effective as of the signature date below and will remain in full force and effect until the DHS has received written notification from an authorized representative of provider at least thirty (30) days in advance of its termination.</li></ol></li></ul>
<ul> <li>On behalf of the health care provider identified above, by my signature below I hereby represent as follows:</li> <li>I authorize the Department of Health Services (DHS) to deposit, by electronic funds transfer, payments owed to the provider by the State of Wisconsin and, if necessary, initiate debit adjustments for any electronic deposits made in error to the account indicated above. I hereby authorize the financial institution/bank named above to credit and/or debit the same to such account.</li> <li>I acknowledge that funds deposited pursuant to this authorization are payments by the State of Wisconsin and are subject to the same laws, rules and policies as payments made in any other manner.</li> <li>I acknowledge that funds deposited pursuant to this authorization are payments by the State of Wisconsin and are subject to the same laws, rules and policies as payments may be erroneously transferred electronically. In the event that due to failure to provide complete or accurate information DHS deposits payments into an account over which the provider does not have control, I agree that DHS shall be held harmless for such payments.</li> <li>I hereby certify that the provider has control of the account referenced above, and that the financial institution and all arrangements between the financial institution and met provider are in compliance with all applicable federal and Automated Clearing House (ACH) regulations and instructions.</li> <li>I acknowledge that any information provided in this document constitutes a statement or representation of a material fact knowingly and willfully made or caused to be made for use in determining rights to payment within the meaning of s.49.49(1) and (4m), Wis. Stats., and that if any such information is false, criminal or other penalties may be imposed under those laws.</li> <li>I acknowledge that this authorization is effective as of the signature date below and will remain in full force and effect until the DHS has received written notification from an authorize</li></ul>
<ol> <li>I authorize the Department of Health Services (DHS) to deposit, by electronic funds transfer, payments owed to the provider by the State of Wisconsin and, if necessary, initiate debit adjustments for any electronic deposits made in error to the account indicated above. I hereby authorize the financial institution/bank named above to credit and/or debit the same to such account.</li> <li>I acknowledge that funds deposited pursuant to this authorization are payments by the State of Wisconsin and are subject to the same laws, rules and policies as payments made in any other manner.</li> <li>I acknowledge that if the provider fails to provide complete and accurate information on this authorization form, the processing of the form may be delayed or my payments may be erroneously transferred electronically. In the event that due to failure to provide complete or accurate information DHS deposits payments into an account over which the provider does not have control, I agree that DHS shall be held harmless for such payments.</li> <li>I hereby certify that the provider has control of the account referenced above, and that the financial institution and all arrangements between the financial institution and the provider are in compliance with all applicable federal and Automated Clearing House (ACH) regulations and instructions.</li> <li>I acknowledge that any information provided in this document constitutes a statement or representation of a material fact knowingly and willfully made or caused to be made for use in determining rights to payment within the meaning of s.49.49(1) and (4m), Wis. Stats., and that if any such information is false, criminal or other penalties may be imposed under those laws.</li> <li>I acknowledge that this authorization is effective as of the signature date below and will remain in full force and effect until the DHS has received written notification from an authorized representative of provider at least thirty (30) days in advance of its termination. The DHS</li></ol>
<ul> <li>to the provider by the State of Wisconsin and, if necessary, initiate debit adjustments for any electronic deposits made in error to the account indicated above. I hereby authorize the financial institution/bank named above to credit and/or debit the same to such account.</li> <li>I acknowledge that funds deposited pursuant to this authorization are payments by the State of Wisconsin and are subject to the same laws, rules and policies as payments made in any other manner.</li> <li>I acknowledge that if the provider fails to provide complete and accurate information on this authorization form, the processing of the form may be delayed or my payments may be eroneously transferred electronically. In the event that due to failure to provide complete or accurate information DHS deposits payments into an account over which the provider does not have control, I agree that DHS shall be held harmless for such payments.</li> <li>I hereby certify that the provider has control of the account referenced above, and that the financial institution and all arrangements between the financial institutions and instructions.</li> <li>I acknowledge that any information provided in this document constitutes a statement or representation of a material fact knowingly and willfully made or caused to be made for use in determining rights to payment within the meaning of s.49.49(1) and (4m), Wis. Stats., and that if any such information is false, criminal or other penalties may be imposed under those laws.</li> <li>I acknowledge that this authorization is effective as of the signature date below and will remain in full force and effect until the DHS has received withten notification from an authorized representative of provider at least thirty (30) days in advance of its termination. The DHS will continue to send the direct deposit to the financial institution indicated above until notified in accordance with this paragraph by an authorized representative of provider that provider wishes to change the financial institution recei</li></ul>
SIGNATURE - Authorized Agent*       I Agree to the statements above         Title*       Image: Comparison of the statement of the stat

Figure 14 Authorization to Make Electronic Fund Payments Page

- 22. Read the Authorization statement.
- 23. Check the box next to "I Agree to the statements above."
- 24. Enter your signature, title, and the date.

Note: This is a legally binding agreement. If you do not agree to these statements, you will not be enrolled in EFT.

25. Click **Next**. The Summary page will be displayed.



Figure 15 Summary Page

26. To preview your request, click **Preview EFT Request**. A draft PDF version of your EFT request(s) will be displayed in a separate window. Each agreement consists of two pages. (Multiple EFT requests will be displayed in one PDF.)

THORIZATION y, Before completing ctions, F-13468A. GUEST Analment ATIONS / CERTIFIC2 Address City NPI) is required for a 88 ON FILE FOR LC	ATIONS IMPAC	TED ZIP Code 53818	Taxonomy Code 100N0000X	Payer (MA, WWWP, WCDP) MA		1.1 advocate the Department of Hadth Services to take of recommon and interaction in the services to take of the services in the transition of the services in the services of the service of the services o	ove, by my signature below i hereby represent as follows: DH6) to deposit, by electronic funds transfer, payments owed to the provider b adjustments for any electronic deposition made in error to the account indicated and named above to credit and/or debit the same to such account. Indicated and and are payments by the State of Wiscomia and are subject to
y, Before completing ctions, F-13468A. IGUEST Anoliment Action8 / CERTIFIC/ Address City NPI) is required for a	ATIONS IMPAC	TED ZIP Code 53818 oviders. Non-he	Taxonomy Code 100N0000X	Payer (MA, WWWP, WCDP) MA	Transfer 88N or EIN	Blate of Wisconsin and, If necessary, Initiate debit above. Hereby subtracts the Minchi antistutions 2.1 I schnowledge that find deposited pursuant to same laws, nuice and policies as payments made i 3.1 schnowledge that fit me provider fails to provide the form may be debyed or my payments may be complete or accurate information DHR depoted be DHB shall be test harmess for such spinnets. 4.1 I hereby certify batt te provider has control of arrangements between the financial institution and House (ACH) regulations and Instructions. 5.1 I schnowledge that my information provided in thronicity and within made crussel be benefits.	adjustments for any electronic deposity, made in error to the account indicates and name advors to creat and/or creatity as and to such account. It is autoratation are payments by the State of Wisconsin and are subject to in any other manner. Is complet and accurate information on this autorization form, the processing emonopuly transferred excitotically. In the event that cale to failure to provide impaired in this autorization activity and the sub- activity of the account referenced acove, and that the financial institution and all the provider are in compliance with all applicable federal and Automated Clear this document constitution a pathoement or representation of a matterial fact this document constitution a pathoement or representation of a naterial fact this document constitution a pathoement or representation of a naterial fact and a constitution a pathoement or representation of a naterial fact and a constitution a pathoement or representation of a naterial fact and a constitution a pathoement or representation of a naterial fact and a constitution activity assessment or representation of a naterial fact and a constitution activity assessment or provident activity and a constitution and and a constitution activity and matterial fact and a constitution activity assessment or provident activity and a constitution and a constitution activity assessment or provident activity and a constitution and activity and activity and activity and activity and and a constitution activity assessment and and activity and activity and activity and activity and activity and activity and activity and activity and activity and activity and activity activity activity activity and activity activity ac
Address Cit	y State	ZIP Code 53818 oviders. Non-he	Code 100N00000X	(MA, WWWP, WCDP) MA	EIN	same laws, rules and policies as payments made 1. actionades that if the provider fails to porvide the form may be depard or my payments may be complete or accurate information DHG seposities DHS shall be held harmless for such payments. 4. I hereby cartly that the omisien has control arrangements between the financial instructions and House (VAL) regulators and instructions. 5. I actionaledge that my information provided in thronoling waithful made crucialed by any optical	In any other manner. Is ony other manners, the constant of the automation form, the processing encroncouply bandferned electronically. In the event that due to failure to prove manners into an account over which the provider does not have the provider are in compliance with all applicable federal and Automated Clear that does not account of the adment of representation of a material host bits document controllates a batternet or representation of a material host bits document controllates and any other than the financial of 42.49(1) and the provider are in compliance with all applicable federal and Automated Clear bits document controllates and the time the memory of a 42.49(1) and of a state of
ATIONS / CERTIFICA Address Cit	y State	ZIP Code 53818 oviders. Non-he	Code 100N00000X	(MA, WWWP, WCDP) MA	EIN	the form may be delayed or my payments may be complete or accurate information DHB deposits pa DHS shall be held harmiess for such payments. 4. I hereby certify that the provider has control of arrangements between the financial institution and House (ACH) regulations and instructions. 5. I acknowledge that any information provided in incovarioury and within made or caused to be mail	emonosuly transferred electronically. In the event that due to failure to provide synthesis that account over which the provider does not have more than the account referenced above, and that the financial institution and all the provider are in compliance with all applicable federal and Automated Clear third accounter constitution a site account of the time memory on a (4.4.44%) and the for use in determining drafts bacement or representation of a matterial had the for use in determining drafts bacement or drafts and a (4.4.4%) and a (4.4.4%).
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	(I health care pr	oviders. Non-he	althcare providers		123436789	knowingly and willfully made or caused to be made	e for use in determining rights to payment within the meaning of \$,49,49(1) and
				may enter their Me		knowingly and willfully made or caused to be made	e for use in determining rights to payment within the meaning of \$,49,49(1) and
				may enter their Me		(4m), Wis, Stats., and that if any such information.	
88 ON FILE FOR LC	DCATIONS / CE	RTIFICATIONS			edicaid	6. I acknowledge that this authorization is effective	e as of the signature date below and will remain in full force and effect until the orized representative of provider at least thirty (30) days in advance of its
			LISTED ABOVE	(Must Be the Sam	e Address for	termination. The DHS will continue to send the dire	ect deposit to the financial institution indicated above until notified in accordance
							re of provider that provider wishes to change the financial institution receiving the provider agrees to submit to the DHS an updated EFT Authorization
						Agreement.	
(Street, City, State.)	ZIP Code)					7. Lacknowledge that the requirements and obliga	ations contained herein are in addition to any and all other requirements and
		2				obligations applicable to provider in connection wit	th provider's participation in any program that is part of Forward Health, includin
						and updates.	from in rederal and state statutes and rules and applicable provider handbook
		E-mail Addr	ess — Contact Per	son			
						<ol> <li>Faman autorized representative of the provid</li> </ol>	er war power to make all representations on provider's behalt contained hereit
erson				n		SIGNATURE — Authorized Agent	Name — Authorized Agent (Printed)
		(608) 11	1-2345				
TUTION INFORMA	TION						Date Signed
							07/28/2011
					and down at	SIGNATURE — Authorized Agent (optional)	Name — Authorized Agent (Printed)
street, Uity, State, 24	0	Checking		Business or Pers	onal Account:	Title	Date Signed
ition	1	elephone Numb	ber — Financial Ins	stution			I
)		ustomer Accou	nt Number				
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		Telephone I	Number — Accour	nt Holder			PROV1UAT
		(608) 55	55-1212 Ext. 1				
						Thursday, July 28, 2011 9:29:11 AM	
N, WI 53719-12	34						
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Figure 16 Draft PDF Version of EFT Request

Note: Do *not* print and fax or mail these requests to ForwardHealth. ForwardHealth does not accept paper enrollments. The enrollment will be submitted when you click Submit on the Summary page.

27. Verify that the information displayed in the draft PDF version is accurate.

To make changes to an EFT request, click **Previous** until you return to the appropriate page. Change the necessary information.

28. Click **Submit** on the Summary page to submit the EFT enrollment request(s). The EFT Request was Submitted page will be displayed.

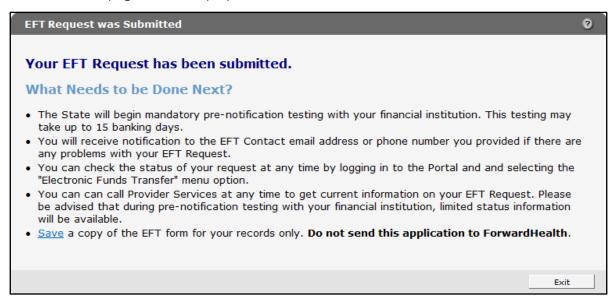


Figure 17 EFT Request Was Submitted Page

The EFT Request was Submitted page confirms that your EFT request(s) was submitted successfully and describes next steps.

- 29. To save a copy of your EFT request(s) for your records, click **Save**. A draft PDF version of your EFT request(s) will be displayed in a separate window.
- 30. Click **Exit**. You will be redirected to the secure Provider page.

# **3** Check the Status of your Electronic Funds Transfer Enrollment

### **3.1 Access Electronic Funds Transfer Enrollment Status** Information

- 1. Access the ForwardHealth Portal at <a href="https://www.forwardhealth.wi.gov/">https://www.forwardhealth.wi.gov/</a>.
- 2. Log in to your secure Provider Portal account.
- 3. Click Electronic Funds Transfer located in the Home Page box on the right of the page.

S wisconsin.gov home state agencies subject directory department of health services	
ForwardHealth Wisconsin serving you Provider	Welcome Inpatient03 UAT > May 7, 2019 2:35 PM Logout
Home         Search         Providers         Enrollment         Claims         Prior Authorization         Remittance Advices         Trade Files           Account         Contact Information         Online Handbooks         Site Map         User Guides         Certification	Health Check Max Fee Home
You are logged in with NPI: 1255334173, Taxonomy Number: 282N00000X, Zip Code: 53226, Financial Payer: Medicaid Providers What's New?	Search Search
Providers can improve efficiency while reducing overhead and paperwork by using real-time applications available on the new ForwardHealth Portal. Submission and tracking of claims and prior authorization requests and amendments, on-demand access to remittance information, 835 trading partner designation, and instant access to the most current ForwardHealth information is now available.	Update User Account     Customize Home Page     Demographic Maintenance     Electronic Funds Transfer     Check My Revaildation Date     Revalidate Your Provider Enrollment     Check Enrollment
New Rate Reform Part 3 Ideas/Recommendations Requested.	
Incentive Payments Are you Eligible?	
ForwardHealth System Generated Claim Adjustments	Quick Links     Register for E-mail Subscription

Figure 18 Electronic Funds Transfer Link

The Introduction page will be displayed.

Introduction
Required fields are indicated with an asterisk (*).
For New EFT enrollments or Changes to Existing EFT Enrollments:
You will need to have the following information available:
<ul> <li>The name and email address for the person in your organization that will serve as the contact for all EFT information.</li> </ul>
<ul> <li>The financial institution's ABA routing number.</li> <li>The account number and the name on record with the bank/financial institution as the Account Holder for the account.</li> </ul>
<ul> <li>The type of account (savings or checking, personal or business).</li> </ul>
Existing EFT Data
<ul> <li>Any existing EFT information will be pre-populated based on the current organization you are logged in with.</li> </ul>
To Check the Status of Your EFT Enrollment:
Click "Next" below and a status screen will appear.
User Guide
• <u>View</u> the EFT user guide.
EFT Processing Overview
<u>View</u> the EFT processing overview.
Next Exit C

Figure 19 Introduction Page

4. Click **Next**. The Electronic Funds Transfer Request page will be displayed.

Organiza	ion List —										
Organiza											
Provider	-		e ZIP	ZIP + 4	Taxonomy	Provider Type	Payer	EFT Status	Add/Change		
	001 LADYSMIT		54848			Physician Group		No EFT on file		View History	
	002 PLATTEVIL		53818	1264	100N00000X		Medicaid	No EFT on file		View History	
	003 COTTAGE		53527		200N00000X		Medicaid	Active		View History	
0000000	004 MIDDLETO	N WI	53562		300N00000X	Dentist	Medicaid	Active		View History	
0000000	005 LADYSMIT	H WI	54848		400N00000X	Physician Group	Medicaid	No EFT on file		View History	
0000000	006 GREEN BA	Y WI	54305		500N00000X	Hospital	Wisconsin Chronic Disease	No EFT on file		View History	
											Select All N
Audit His	tory										

Figure 20 Electronic Funds Transfer Request Page

If you are an EFT clerk, this page will display all the service locations for which you are assigned the EFT role. Account administrators will see all of the service locations for the provider under which they are logged in.

The EFT Status column displays the current status of each service location.

#### **3.1.1 Enrollment Statuses**

#### Pending

A *Pending* status indicates that ForwardHealth is preparing to initiate the required prenotification test transaction with the financial institution designated as your organization's ForwardHealth EFT settlement account.

#### Prenotification

A *Prenotification* status indicates that ForwardHealth has initiated the prenotification test transaction with the designated financial institution and is awaiting a response. Prenotification testing can take up to 15 banking days to complete. A *Prenotification* status also indicates that ForwardHealth has not received notification of any error in the EFT account set-up from the financial institution during the testing process to date.

#### Active

An *Active* status indicates that the required prenotification testing process has been completed without error. The next scheduled payment will be made by EFT and the payments directly deposited into the provider's EFT settlement account at the designated financial institution.

The EFT enrollment will remain in an *Active* status unless you change your enrollment information or the financial institution initiates a change in their ABA routing number or settlement account information.

#### Failed

A *Failed* status indicates that errors occurred during the required prenotification test process with the designated financial institution. If this occurs, ForwardHealth will work with the provider's financial institution to resolve the errors and generate a second prenotification test with the financial institution. When necessary, ForwardHealth will contact the EFT contact person identified on the EFT enrollment form for your organization to verify or correct information.

#### Interrupt

An *Interrupt* status is a temporary status that forces a paper check to be issued. Electronic funds transfers will only be placed in this status at the direction of ForwardHealth. The EFT account remains valid while the account is in an *Interrupt* status and can be placed back into an *Active* status to resume scheduling EFTs.

#### No EFT on File

A *No EFT on file* status indicates that an EFT request has not been submitted for a specific service location or that an EFT request has been canceled.

## **3.2 View History**

To view the enrollment history for a specific service location, click **View History** next to the specific service location. The "Audit History" section will populate with any changes made to the EFT enrollment for the selected service location.

<ul> <li>Organizations</li> <li>To view the a</li> <li>Organization Li</li> </ul>	audit history of						from the list below.			
Organization Li	ict									
	150									
Organization L							_			
Provider ID Ci 0000000001 L/		State WI	<b>ZIP</b> 54848	ZIP + 4	Taxonomy 000N00000X	Provider Type Physician Group	Payer Medicaid	EFT Status No EFT on file	Add/Change	View History
				1001	100N00000X		Medicaid	No EFT on file		
000000002 PL		WI	53818	1264						View History
	OTTAGE GROVE	WI	53527		200N00000X		Medicaid	Active		View History
000000004 M		WI	53562		300N00000X		Medicaid	Active		View History
000000005 L/		WI	54848			Physician Group		No EFT on file		View History
000000006 G	REEN BAY	WI	54305		500N00000X	Hospital	Wisconsin Chronic Disease	No EFT on file		View History
										Select All
Audit History										
Audit History										
	ction			Desc	ription of Actio	'n				
Date At			indicato	r	(-	and the strength of the	hanged from Personal to Busi			
udit History Judit History										
Data Ar			indicato	-	-					

Figure 21 Electronic Funds Transfer Request Page

# 4 Update Information on an Active Electronic Funds Transfer

In order to change information for an EFT enrollment, the enrollment must be in an *Active* status. To update or change information for an active EFT enrollment, complete the following steps:

- 1. Access the ForwardHealth Portal at <a href="https://www.forwardhealth.wi.gov/">https://www.forwardhealth.wi.gov/</a>.
- 2. Login to your secure Provider Portal account.
- 3. Click Electronic Funds Transfer located in the Home Page box on the right of the page.

Wisconsin.gov home state agencies subject directory department of health services	
ForwardHealth Wisconsin serving you	Welcome Inpatient03 UAT > May 7, 2019 2:35 PM Logout
Home         Search         Providers         Enrollment         Claims         Prior Authorization         Remittance Advices         Trade Files           Account         Contact Information         Online Handbooks         Site Map         User Guides         Certification	Health Check Max Fee Home
You are logged in with NPI: 1255334173, Taxonomy Number: 282N00000X, Zip Code: 53226, Financial Payer: Medicaid Providers	Search Search
Providers can improve efficiency while reducing overhead and paperwork by using real-time applications available on the new ForwardHealth Portal. Submission and tracking of claims and prior authorization requests and amendments, on-demand access to remittance information, 835 trading partner designation, and instant access to the most current ForwardHealth information is now available.	Update User Account     Customize Home Page     Demographic Maintenance     Electronic Funds Transfer     Check My Revalidation Date     Revalidate Your Provider Enrollment     Check Enrollment
New Rate Reform Part 3 Ideas/Recommendations Requested.	
Incentive Payments Are you Eligible?	
ForwardHealth System Generated Claim Adjustments	Quick Links
	Register for E-mail Subscription

Figure 22 Electronic Funds Transfer Link

The Introduction page will be displayed.

Introduction
Required fields are indicated with an asterisk (*).
For New EFT enrollments or Changes to Existing EFT Enrollments:
You will need to have the following information available:
<ul> <li>The name and email address for the person in your organization that will serve as the contact for al EFT information.</li> </ul>
<ul> <li>The financial institution's ABA routing number.</li> <li>The account number and the name on record with the bank/financial institution as the Account Holder for the account.</li> </ul>
<ul> <li>The type of account (savings or checking, personal or business).</li> </ul>
Existing EFT Data
<ul> <li>Any existing EFT information will be pre-populated based on the current organization you are logged in with.</li> </ul>
To Check the Status of Your EFT Enrollment:
Click "Next" below and a status screen will appear.
User Guide
• <u>View</u> the EFT user guide.
EFT Processing Overview
<u>View</u> the EFT processing overview.
Next Exit C

Figure 23 Introduction Page

4. Click **Next**. The Electronic Funds Transfer Request page will be displayed.

	e indicated with a	an aste	ansk (* ,								
	FT user guide.										
	organization(s) t ons that currently										
							from the list below.				
• 10 New an	addit history of	anoig	Janizadi	on, selec	cule view	inscory buccon	from the list below.				
Organization	n List										
		_	_	_							
Organizatio Provider ID		State	ZID	$7ID \pm 4$	Taxonomy	Provider Type	Payer	EFT Status	Add/Change	_	_
	LADYSMITH	WI	54848		•	Physician Group	•	No EFT on file		View History	
000000002	PLATTEVILLE	WI	53818	1264	100N00000X		Medicaid	No EFT on file		View History	
000000003	COTTAGE GROVE	WI	53527		200N00000X	Pharmacy	Medicaid	Active		View History	
0000000004	MIDDLETON	WI	53562		300N00000X	Dentist	Medicaid	Active		View History	
000000005	LADYSMITH	WI	54848		400N00000X	Physician Group	Medicaid	No EFT on file		View History	ĺ
000000006	GREEN BAY	WI	54305		500N00000X	Hospital	Wisconsin Chronic Disease	No EFT on file		View History	
											Select All N
											bereet rin <u>r</u>
Audit Histor											
	,										
Audit Histo			_	_							_
*** No rows for	und ***										

Figure 24 Electronic Funds Transfer Request Page

If you are an EFT clerk, this page will display all the service locations for which you are assigned the EFT role. Account administrators will see all of the service locations for the provider under which they are logged in.

- 5. Verify that the EFT account you wish to change is in an *Active* status.
- 6. Check the Add/Change box for each service location that you wish to modify. If all the service locations listed are to be modified, click **Select All** to check all the boxes.

Note: When more than one service location is selected, all the information revised in the succeeding pages will apply to all the service locations selected. If there is any difference in the EFT information used between service locations, including demographic information, email addresses, ABA routing numbers, EFT settlement account numbers, and account types, the service locations must be revised separately.

7. Click **Next**. The General Information page will be displayed.

General Information		9
Required fields are indicated with	an asterisk (*).	
<ul> <li><u>View the EFT User Guide</u></li> <li>If you need to change the through the portal.</li> </ul>	tax information below, please go to the <u>Demographic Maintenance Tool</u> to submit your new information	
Pay To Address		
Name - Business or Individual	STATE UNIVERSITY	
Street Address Line 1	123 MAIN STREET	
Street Address Line 2	MEDICAL FOUNDATION	
	ANYTOWN	
State/ZIP	WI 💙 55555 -	
Contact Information         Name - Contact Person*         Primary E-mail Address*         jane         Telephone Number*         (608)         Fax Number         Other EFT Contact Notificati         E-mail Address 1         john.smith@         E-mail Address 3         E-mail Address 4	a. doe@abc.com 3)555-5555 Ext. 3)555-5555	
Tax Identification Informatic Taxpayer Identification Numbe Name - FEI		
	Previous Next Exit	

Figure 25 General Information Page

8. If you are not changing any information on this page, click **Next**.

To make any changes to the "Contact Information" or "Other EFT Contact Notification Addresses" sections, enter the changes in the appropriate fields. Once the information has been entered, click **Next**.

The Financial Institution Information page will be displayed.

Financial Institution Inform	ation	3
Required fields are indicated w	ith an asterisk (*).	
• <u>View</u> the EFT user guide		
C Search Criteria		
ABA Routing Number		
Financial Institution Name		
		Search <u>*</u>
Search Results		
Financial Institutions		
ABA Number Name 070707070 GENERAL BAN	K GREEN BAY, N.A. GREEN BAY WI	
L		
Selected Financial Institut	ion	
ABA Routing Number	070707070	
Financial Institution Name	GENERAL BANK GREEN BAY, N.A.	
Address Line 1		
Address Line 2		
City	GREEN BAY	
State/ZIP	WI -	
Telephone Number	Ext.	
L		
	Previous Next	Exit C

Figure 26 Financial Institution Information Page

9. If you are not changing any information on this page, click **Next**.

To change the financial institution receiving the EFT payment, enter the ABA routing number or name of the financial institution in the "Search Criteria" section and click **Search**. A list of the available financial institutions matching your search criteria will be displayed in the "Search Results" section. From the displayed list, click the financial institution whose information matches the ABA routing number, name, and address of the institution that your organization has an account with and that your organization wishes to designate as your new ForwardHealth EFT financial institution. Information for the selected financial institution will be displayed in the "Selected Financial Institution" section. Verify that the populated information is correct. Click **Next**.

The Account Information page will be displayed.

Account Information		?
Required fields are indicated	I with an asterisk (*).	
• <u>View</u> the EFT user gu	ide.	
Account Information		
Customer Account Nu	mber* 111111111	
Type of Acc	count*  Checking  Savings	
Business or Personal Acc	count* 📀 Business 🖸 Personal	
Account Holder Inform		
Name - Account Holder*	JANE DOE	
Street Address Line 1*	7 CHERRY TREE LANE	
Street Address Line 2		
City*	MADISON	
State/ZIP*	WI <b>v</b> 55555 -	
Telephone Number*	(608)555-5555 Ext.	
L		
	Previous Next Ex	iit <u>C</u>

Figure 27 Account Information Page

10. If you are not changing any information on this page, click **Next**.

If you have changed to another financial institution, enter the provider's account information in the appropriate fields. If you are revising information for the provider's current institution, make the necessary changes. Click **Next**.

The Authorization to Make Electronic Fund Payments page will be displayed.

Authorization to Make Electronic Fund Payments	?
Required fields are indicated with an asterisk (*).	
• <u>View</u> the EFT user guide.	
On behalf of the health care provider identified above, by my signature below I hereby represent as follows:	
<ol> <li>I authorize the Department of Health Services (DHS) to deposit, by electronic funds transfer, payments owed to the provider by the State of Wisconsin and, if necessary, initiate debit adjustments for any electronic deposits made in error to the account indicated above. I hereby authorize the financial institution/bank</li> </ol>	
named above to credit and/or debit the same to such account.	
<ol><li>I acknowledge that funds deposited pursuant to this authorization are payments by the State of Wisconsin and are subject to the same laws, rules and policies as payments made in any other manner.</li></ol>	
3. I acknowledge that if the provider fails to provide complete and accurate information on this authorization	
form, the processing of the form may be delayed or my payments may be erroneously transferred electronically. In the event that due to failure to provide complete or accurate information DHS deposits	
payments into an account over which the provider does not have control, I agree that DHS shall be held harmless for such payments.	
4. I hereby certify that the provider has control of the account referenced above, and that the financial	
institution and all arrangements between the financial institution and the provider are in compliance with all applicable federal and Automated Clearing House (ACH) regulations and instructions.	
5. I acknowledge that any information provided in this document constitutes a statement or representation of a	
material fact knowingly and willfully made or caused to be made for use in determining rights to payment within the meaning of s.49.49(1) and (4m), Wis. Stats., and that if any such information is false, criminal or	
other penalties may be imposed under those laws. 6. I acknowledge that this authorization is effective as of the signature date below and will remain in full force	
and effect until the DHS has received written notification from an authorized representative of provider at	
least thirty (30) days in advance of its termination. The DHS will continue to send the direct deposit to the financial institution indicated above until notified in accordance with this paragraph by an authorized	
representative of provider that provider wishes to change the financial institution receiving the direct	
deposit. If provider's EFT information changes, provider agrees to submit to the DHS an updated EFT Authorization Agreement.	
7. I acknowledge that the requirements and obligations contained herein are in addition to any and all other	
requirements and obligations applicable to provider in connection with provider's participation in any program that is part of ForwardHealth, including but not limited to requirements and obligations set forth in federal	
and state statutes and rules and applicable provider handbooks and updates. 8. I am an authorized representative of the provider with power to make all representations on provider's behalf	
contained herein.	
I Agree to the statements above	
I Agree to the statements above	
SIGNATURE - Authorized Agent*	
Title*	
Date Signed*	
Previous Next Exit (	2

Figure 28 Authorization to Make Electronic Fund Payments Page

- 11. Read the Authorization statement.
- 12. Check the box next to "I Agree to the statements above."
- 13. Enter your signature, title, and the date.

Note: This is a legally binding agreement.

14. Click **Next**. The Summary page will be displayed.



Figure 29 Summary Page

15. To preview your request, click **Preview EFT Request**. A draft PDF version of your EFT request(s) will be displayed in a separate window. Each agreement consists of two pages. (Multiple EFT requests will be displayed in one PDF.)

DEPARTMENT O Division of Health F-13468 (05/09)							STATE C	F WISCONSIN	DIRECT DEPOSIT AUTHORIZATION FOR ELECTRON F-15468 (0200)		Page 2 e
					HEALTH				SECTION VII — AUTHORIZATION TO MAKE E On behalf of the health care provider identified a	ELECTRONIC FUND PAYMENTS bove, by my signature below I hereby represent as follows:	
	ype or print cle	arly. Before co	mpleting this			INDS TRANS			State of Wisconsin and, If necessary, initiate deb	(DHS) to deposit, by electronic funds transfer, payments owe it adjustments for any electronic deposits made in error to the Ibank named above to credit and/or debit the same to such a	account indicated
	Enrolment								<ol><li>I acknowledge that funds deposited pursuant same laws, rules and policies as payments made</li></ol>	to this authorization are payments by the State of Wisconsin in any other manner.	and are subject to the
	to existing EFT nination Reque									de complete and accurate information on this authorization for e erroneously transferred electronically. In the event that due	
SECTION II - I		CATIONS / CE	RTIFICATIO	INS IMPA	CTED					payments into an account over which the provider does not h	
For Health Can	e Providers						Payer				
NPI* or Provider ID	Name	Address	City	State	ZIP Code	Taxonomy Code	(MA, WWWP, WCDP)	SSN or EIN		f the account referenced above, and that the financial institut nd the provider are in compliance with all applicable federal a	
000000001			-	-	53818	100N00000X	MA	123456789	5 I acknowledge that any information provided it	in this document constitutes a statement or representation of	a material fact
									knowingly and willfully made or caused to be ma	de for use in determining rights to payment within the meanin is faise, criminal or other penalties may be imposed under t	o of \$,49,49(1) and
A Material Di	rouider Identifie	er (NDI) is secul	and the all he	alth care o	rouider: Nor-hi	althcare providers	man aniar their M	adicald			
Provider ID.	TOYIDE IDENTIC	er (ren) is requ	red for all he	ann care p	roviders, Norris	are care providers	may enter their w	eulau		we as of the signature date below and will remain in full force thorized representative of provider at least thirty (30) days in .	
	PAY TO ADD	RESS ON FILE	FOR LOCA	TIONS / C	ERTIFICATION	LISTED ABOVE	(Must Be the Sam	e Address for	termination. The DHS will continue to send the d	irect deposit to the financial institution indicated above until n	otified in accordance
Al Locations) Name — Busine	en or individua									tive of provider that provider wishes to change the financial in ges, provider agrees to submit to the DHS an updated EFT A	
COUNTY C		-							Agreement.		
Address - Busi			, State, ZIP	Code)						pations contained herein are in addition to any and all other n	
900 NELSO	ON AVE P	LATTEV	LLE, WI	5381	8					with provider's participation in any program that is part of Forw et forth in federal and state statutes and rules and applicable	
SECTION IV -		FORMATION F	OR EFT NO	TIFICATIO					and updates.		
Name — Contac						ess - Contact Per			8. I am an authorized representative of the prov	ider with power to make all representations on provider's beh	all contained herein.
JANE DOE		-				e@abc.com					
(920) 123-4			Ext. 1111		(608) 11		n		SIGNATURE — Authorized Agent	Name — Authorized Agent (Printed)	
(920) 123-4 SECTION V 1					(008) 11	1-2340			Jane Doe Title	Date Signed	
SECTION V = 1 Name — Financ		ISTITUTION IN	FORMATION	•					Finance Director	07/28/2011	
SENERAL	BANK GR	EEN BAY	NA						SIGNATURE — Authorized Agent (optional)	Name — Authorized Agent (Printed)	
Address — Fina					Type of Account		Business or Pers	onal Account:			
, GREEN BAY, WI				Checking 🔯 E		Business Personal		Title	Date Signed		
Contact Name -	- Financial Ins	stution		Ť	Telephone Num	ber — Financial In:	stitution			I	
ABA Routing Nu					Customer Accou	nt Number					
<u>0 7 5 9</u>	005	7.5			12345678912111213				Internal Use Only Audt - User Name	Audit - User ID	
SECTION VI -		OLDER INFOR	MATION								
Name — Accou	nt Holder					Number — Accou			Test Provider Audit - Date/Time	PROV1UAT	
IMIN CHARGE (608) 555-1212 Ext. 1 Address — Account Holder (Street, City, State, ZIP Code)					55-1212 Ext. 1						
									Thursday, July 28, 2011 9:29:11 AM		
123 VP LA	NE, MADIS	ON, WI 53	719-1234								
						-DF	RAF	Continued		-DR/	\FT-
						-DF	RAF			-DR/	٩FT

Figure 30 Draft PDF Version of EFT Request

Note: Do *not* print and fax or mail these requests to ForwardHealth. ForwardHealth does not accept paper enrollments. The enrollment will be submitted when you click Submit on the Summary page.

- 16. Verify that the information displayed in the draft PDF version is accurate. To make changes to an EFT request, click **Previous** until you return to the appropriate page. Change the necessary information.
- 17. Click **Submit** on the Summary page to submit the EFT enrollment request(s). The EFT Request was Submitted page will be displayed.

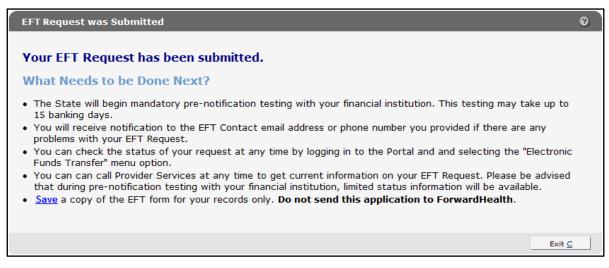


Figure 31 EFT Request Was Submitted Page

The EFT Request was Submitted page confirms that your EFT request(s) was submitted successfully and describes the next steps.

- 18. To save a copy of your EFT request(s) for your records, click **Save**. A draft PDF version of your EFT request(s) will be displayed in a separate window.
- 19. Click **Exit**. You will be redirected to the secure Provider page.

# **5** Email Notifications

An EFT contact will receive an email notification in the following situations.

## **5.1 Change of Email Address**

When the email address for an EFT contact is changed, an email message is sent to the original address, alerting the contact that the address has been changed in ForwardHealth's records. The message also indicates that the EFT contact should alert the provider's account administrator immediately if the change was made in error.

The message contains the following contact information in order to verify the correct address was changed:

- Provider ID/National Provider Identifier (NPI).
- Taxonomy number (if applicable).
- ZIP code.
- Financial payer.

## 5.2 Change of Electronic Funds Transfer Bank Information

When EFT bank information is changed, an email message noting that the key EFT account information (such as financial institution, account number, account type, account holder's name) has been changed is sent to the provider's EFT contact. In addition, an email message indicating that EFT information has been revised will be sent to the provider's account administrator's messaging account.