STATE OF ARIZONA – ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

ACH VENDOR AUTHORIZATION FORM

ATTN: AHCCCS FINANCE – M.D. 5400, P.O. BOX 25520, PHOENIZ, AZ. 85002-5520

AHCCCS Finance Section Fax # 602-258-5943 AHCCCS Website: www.azahcccs.gov

Transaction Type – Check the applicable transaction(s) and complete the sections indicated.

SECTION 1

Please complete Section 2 and 3 below; your financial institution *must* complete Section 4 prior to returning the form to AHCCCSA.

New ACH Setup: _____ Change Account Type: _____ Change Account Number: _____ Change Financial Institution: _____

If you are requesting a Cancellation, please check the box and complete Section 2, 3, and 5 ☐ CANCELLATION REQUEST

SECTION 2

PAYEE IDENTIFICATION

1. Federal Employer's Identification Number (EIN) |_|_|-|_|_|_|_|_|_|_|_|

Or

Social Security Number (SSN) |_|_|_| -|_|_|-|_|_|_|_|

Disclosure of your Social Security Number is voluntary pursuant to 42 U.S.C. 405(c)(2)(C). The State of Arizona will use your EIN or SSN to file required information returns with the Internal Revenue Service.

AHCCCS Provider Number and Locator Code: _____ **This must be completed or request may be denied.**

2. _____ _____ 3. (_|_|_)-|_|_|_|-|_|_|_|_|

Payee's Name – Please Print Provider Name – Please Print Business Telephone – (Area Code and Number)

4. Address: _____ 5. City: _____ State: _____ Zip Code: |_|_|_|_|_|-|_|_|_|_|

SECTION 3

AUTHORIZATION FOR SETUP, CHANGES OR CANCELLATION

6. I authorize the Arizona Health Care Cost Containment System Administration (AHCCCSA) to process payments owed to me via Automated Clearing House (ACH) deposits. AHCCCSA shall deposit the ACH payments in the financial institution and account designated below.

I recognize that if I fail to provide complete and accurate information on this authorization form, the processing of the form may be delayed or made impossible or my electronic payments may be erroneously made.

I authorize AHCCCSA to withdraw from the account all amounts deposited electronically in error. If the designated account is closed or has an insufficient balance to allow withdrawal, then I authorized AHCCCSA to withhold payment owed to me by them until the erroneous deposited amounts are repaid. If I decide to change or revoke this authorization, I recognize that I must forward such notice to AHCCCSA. The change or revocation is effective on the day that AHCCCSA processes the request.

I certify that I have read and agree to comply with AHCCCSA's rules governing payments and electronic transfers as they exist on the date of my signature on this form or as subsequently adopted.

I authorize AHCCCSA to stop making electronic transfers to my account without advance notice.

I certify that I am authorized to contract for the entity receiving deposits, pursuant to this agreement and that all information provided is accurate.

The financial institution can process CTX payments/transactions along with addendum information. **YES** _____ **NO** _____

7. _____ 8. _____

(Required) Payee's Name – Please Print (Required) Title – Please Print

9. _____ 10. _____

(Required) Payee's Signature (Required) Date

SECTION 4

FINANCIAL INSTITUTION – Must be completed by the financial institution representative

11. Bank Name: _____

12. Bank Address: _____ City: _____ State: _____ Zip Code: |_|_|_|_|_|-|_|_|_|_|

13. Routing Transit Number: |_|_|_|_|-|_|_|_|_|-|_| 14. Customer Account Number: |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

15. Type of Account: Checking _____ Savings _____

16. _____ 17. _____ 18. (_|_|_)-|_|_|_|-|_|_|_|_|

(Required) Financial Institution Representative Name – Please Print (Required) Title – Please Print Telephone - (Area Code and Number)

19. _____ 20. _____

(Required) Financial Institution Representative's Signature (Required) Date

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CANCELLATION

21. Reason: _____ 22. Date: _____

SECTION 6

AHCCCSA USE ONLY

23. Provider information verified by: _____ Does Provider have aged invoice balance? Yes _____ Amount $ _____ No: _____

24. Provider ACH Approved by: _____ Effective begin date: _____

25. Comments: _____

COMPLETED BY: _____ **DATE:** _____