Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER (EFT) OF MASSHEALTH PAYMENTS

The undersigned hereby authorizes the Executive Office of Health and Human Services, through the State Treasurer, to deposit funds due into the bank account named below. This authorization will remain in effect until canceled or amended in writing.

Visit the MassHealth Web site at www.mass.gov/masshealth for more information.

Please check one: ☐ Initial authorization ☐ Modification to existing authorization

MassHealth Provider No.:_____ Tax Identification No.:_____
(Leave blank if you are a new provider.)

Provider Name:_____
(Please indicate "doing business as" name and address.)

Street Address:_____

City:_____ State:_____ ZIP:_____-_____

Bank Name:_____

Bank Transit Routing Number:_____

Bank Account Number:_____

Please check account type: ☐ Checking Account ☐ Savings Account ☐ Lock Box

Authorized Signature:_____

Name:_____ Title:_____

Date:_____ E-mail:_____

Attach a voided check or bank statement from the designated account to ensure that the request is processed accurately. Mail completed application form to the following address.

MassHealth
Attn: Provider Enrollment and Credentialing
P.O. Box 9118
Hingham, MA 02043

The State Treasurer is authorized to debit the account only to adjust any over-deposit that it has caused to the account. This debit would be for EFT corrections if the Commonwealth sent an erroneous EFT to the above account.