Electronic Funds Transfer (EFT)
Payment Authorization Agreement for Direct Deposit

Section 1 - Type of Transaction

☐ Add ☐ Change/Update ☐ Inactivate

Section 2 - Contact Information

Employer Identification Number (EIN) or Social Security Number (SSN): | | | | | | | | | |

(no dashes or spaces)

Legal Business or Individual Name: _____

Business Name, Trade Name, Doing Business As: _____
(If different than above)

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Phone Number: _____

Section 3 - State Agency Disbursing Payment

☐ Medicaid Provider
(Provider number, NPI number, and Assigning Authority required)

Provider # | | | | | | | |

NPI # | | | | | | | | | | |

Assigning Authority

☐ Lottery Winner ☐ All others

Section 4 - Prior Financial Information (change / update account)

Prior Financial Institution Name: _____

Account Type: ☐ Checking ☐ Savings

Prior Account Number: | | | | | | | | | | | | | | | | |

(Account Number must match account number on file)

Prior Transit Routing / ABA Number: | | | | | | | | | |

(Routing Number must match routing number on file)

Section 5 - New Financial Information (bank verification must be attached)

New Financial Institution Name: _____

Account Type: ☐ Checking ☐ Savings

New Account Number: | | | | | | | | | | | | | | | |

(Account Number must match attached bank verification)

New Transit Routing / ABA Number: | | | | | | | | | |

(Routing Number must match attached bank verification)

Section 6 - Agreement

* Account changes must be reported to OBM Shared Services (OSS) thirty (30) days prior to the effective date.

* All EFT accounts are tied to an address in our system; a form is required for each address (if needed).

* The entity listed hereby authorizes the Ohio Office of Budget and Management (OBM) to initiate credit entries to its account in the financial institution identified above. Additionally, this form provides OBM the authority to debit any erroneous credit or transfers to the account in the amount of the transfer. This authority is to remain in effect until revoked by us in writing to OSS, a division of OBM.

☐ I have attached a copy of a current voided check or included a bank letter on bank letterhead signed by a bank representative.

☐ Medicaid PROVIDERS – I have ensured the Name, Address, TIN, NPI# & Provider Number matches the information in the MITS Medicaid Web Portal .

☐ I have printed and signed the form

Select one of the following methods to submit this form:

Email:
supplier@ohio.gov

Mail:
OBM Shared Services, ATTN: Supplier Operations
P.O. Box 182880, Columbus, Ohio 43218-2880

Fax:
1-614-485-1052

To ensure all information is captured, please use **Adobe Acrobat Reader** (click HERE for free download) or **Adobe Acrobat Pro ONLY** to fill out and save this form**.** Some data fields and functionality of this form are not fully supported by third-party editing software such as PDF-Xchange.