AUTHORIZATION AGREEMENT FOR AUTOMATIC PAYMENTS/DEPOSITS

I (we) hereby authorize Molina Medicaid Solutions, acting as Fiscal Agent for the State of New Jersey, Division of Medical Assistance and Health Services, to initiate credit entries to my (our) checking account and the depository bank indicated below, hereinafter called Depository, to credit the same to such account.

DEPOSITORY NAME _____ **BRANCH** _____

CITY _____ **STATE** _____ **ZIP** _____

BANK TRANSIT/ABA NO _____ **ACCOUNT NO.** _____

This authority is to remain in effect until the Fiscal Agent has received written notification from me (or either of us) of its termination in such time and in such manner as to afford the Fiscal Agent a reasonable opportunity to act on it.

BANK ACCOUNT NAME _____
(Print account name exactly as it appears on your statement)

PROVIDER NAME _____

PROVIDER NO. _____ **TELEPHONE NO.** _____

NPI # _____

ADDRESS _____

_____

_____ _____ **DATE** ____/____/____
Printed Name Signature

_____ _____ **DATE** ____/____/____
Printed Name Signature

REMARKS _____

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NOTES:

1. To insure accuracy of the bank account numbers, it is imperative that you attach a **BLANK, VOIDED CHECK** verifying the above bank ABA and account numbers.
2. If a joint account, both owners must sign request form.
3. New Jersey Medicaid payments are deposited to your account each Friday at 9:00 a.m.
4. Once Molina Medicaid Solutions has received a **completed** authorization for payments/deposits, it will take approximately 4 weeks before the first deposit is completed electronically to your account. To verify this information, please call your bank and specifically ask for the **ACH Department**.
5. For those providers who previously had Direct Deposit, you will now receive paper checks until the new information is processed.
6. Please make a copy of this before mailing to Molina Medicaid Solutions.

PROVIDER INSTRUCTIONS FOR COMPLETING AUTHORIZATION AGREEMENT FORM

1. DEPOSITORY NAME ..... Name of bank servicing your checking account.
2. BRANCH ..... Name of bank branch.
3. CITY ..... City or town location of bank branch.
4. STATE ..... State location of bank branch.
5. ZIP ..... Zip code of bank branch.
6. BANK TRANSIT/ABA NUMBER ..... Bank routing number (see below, voided check example).
7. BANK ACCOUNT NUMBER ..... Checking account number (see below, voided check example).
8. BANK ACCOUNT NAME ..... Actual account name per your bank's records.
9. PROVIDER INFORMATION ..... Provider name, Medicaid/NJ FamilyCare Provider No., telephone No., address, date prepared and signature.

MAIL THE COMPLETED AUTHORIZATION AGREEMENT AND VOIDED CHECK TO:

Provider Enrollment Unit
Molina Medicaid Solutions
P.O. Box 4804
Trenton, NJ 08650-4804

NOTE: Attach blank, voided check per below sample.