

Electronic Funds Transfer (EFT) Authorization Form Puerto Rico Medicaid Program

Instructions: Form to be completed only by Federally Qualified Health Center (FQHC) providers, Managed Care Organizations (MCOs), and Medicare Advantage Organizations (MAOs). The form must be completed in all its parts, signed and dated by the authorized representative of the entity. Signed by hand or validated electronic signature are required; typed-in signatures are not allowed.

FQHC: Form must be sent via Provider Secure Communications (PSC) portal https://psc.prmmis.pr.gov/.

MCO/MAO: Form must be sent via encrypted email to Gainwell FinCap Help Desk prmmis edi support@gainwelltechnologies.com.

Type of Request: ☐ Update to EFT Information ☐ Add New EFT Information				
PROVIDER / MCO / MAO INFORMATION				
Legal Business Name:				
Medicaid ID / Trading Partner ID: NPI (NPI (for FQI	HC):	Tax ID:
Physical Address:				
City: State:		Zip Code:		
Name and Title of Contact Person for Billing and Payments:				
Contact Phone Number:			Contact Email:	
FINANCIAL INSTITUTION INFORMATION				
ABA (Transit Routing) Number: Finance			cial Institution Name	e:
Address:				Phone Number:
City:	State:	Zip Cod	e:	Extension:
Account Type: Checking Savings Account Number:				
AUTHORIZING SIGNATURE				
AUTHORIZING SIGNATURE: By signing this document, you are authorizing EFT payments for Puerto Rico Medicaid Program to be sent to the above account.				
Printed Name:			Signature:	
Title:			Date:	