

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health
Medical Assistance Administration



Dear Medicaid Provider:

As an added service for our Medicaid providers, the Medical Assistance Administration (MAA) is offering the direct deposit option for your Medicaid claims payments. MAA implemented the direct deposit program for all Medicaid providers in 2003. As a result, this program enabled the District of Columbia to realize cost savings and increase efficiencies by replacing claims payment checks with electronic transfer of funds to Medicaid providers.

Your money will be credited directly to your account within 48 hours after the District's Office of Finance and Treasury (OFT) releases payment to all vendors. You will continue to receive the standard Medicaid remittance advice informing you of each direct deposit transaction.

To take advantage of the convenience and speed of direct deposit, please complete the enclosed (4) forms, make a copy for your records and return the originals to the following address. Enclosed are instructions to follow for completing the forms.

ACS
P.O. Box 34761
Attn: Provider Enrollment
Washington, DC 20043

To ensure timely processing, the enclosed forms listed below need to be completely filled out.

- Medicaid Provider ACH/Direct Deposit Enrollment Form
- W-9 Form – Request for Taxpayer Identification & Certification
- Direct Deposit Authorization Form
- Supplier/Vendor Information Form

Please allow four to six weeks to establish your direct deposit account. If you have any questions regarding this option, please contact the Office of Program Operations on 202-698-2000.

Sincerely,
Office of Program Operations
Medical Assistance Administration

For Completing Direct Deposit Enrollment Forms (4)

The following instructions will assist you in completing the four (4) forms listed below. It is necessary to give full and accurate information for each question to ensure enrollment in the District of Columbia Medical Assistance Administration's (MAA) Direct Deposit Plan. If you have more than one Medicaid provider number (assigned by ACS), you will need to complete a complete packet (4 forms) for each Medicaid provider number.

Return all completed forms to ACS as soon as possible. Please direct all questions regarding these four (4) forms to the Provider Services Unit at 202-906-8318 or 202-698-2000. Allow 6-8 weeks processing time.

INSTRUCTIONS

1. Medicaid Provider ACH/Direct Deposit Enrollment Form

(Please complete all fields)

Please complete all fields and have this signed by the Chief Financial Officer or authorized representative.

- Name of Provider – actual provider name
- Medicaid Provider Number – 9-digit number assigned by ACS
- Federal Tax Identification Number
- ABA/Routing Transit Number – checking account information from bank
- Address, City, State, Zip – address of provider
- Point of Contact – person to contact for additional information
- Section 2 – have CFO print and sign this section

2. W-9 Form – Request for Taxpayer Identification & Certification

(Provide “either” your Employer Tax ID number or Social Security number – do not provide both!)

Detailed instructions are on pages 2, 3, and 4 of the form. Enter information that is on file with the Internal Revenue Service (IRS).

- Name – enter your “company name” or the name of your organization as registered on file with the IRS on Line #1; only complete Line #2 if the “company name” is different.
- Business Name – list trade names used, if any
- Type – if incorporated, select “Corporation”
- Address – enter address on file with the IRS
- Part I – enter employer identification number (i.e., TAX ID); only provide your Social Security number if you do not have an employer identification number
- Part II – have appropriate official (i.e., CEO, CFO, VP) sign and date form
- Print the name of the person signing the form directly below the signature line

3. Direct Deposit Authorization Form

(Your bank must complete and sign this form)

Complete Sections 1 and 2. Your BANK must complete, verify, and sign Sections 1 and 3. An official bank representative must sign and date the form. You can also include a “voided” deposit slip for the account that claims payments should be transmitted to.

- Name of Person entitled to Payment – enter name of organization
- Government Agency Name – agency name and/or department
- Government Agency Address – address of agency and/or department
- Name and Address of Financial Institution – enter bank name and branch
- Type of Depositor – select “Checking”
- Depositor Account Number – enter checking account number
- ABA/Routing Transit Number – have bank complete this section

4. Supplier/Vendor Information Form

(Complete Sections 1 and 3)

Column 1, Row 1 – select “New Vendor

Business Entity Section

- Attorney – select “N” for no
- Supplier Vendor Type – select 5 for vendor-business and circle (5) on page 2, question #6
- Ownership Code – select “N” for medical corporation and circle (N) on page 2, question #7 Note: If address in question #1 is out of the District of Columbia, select “O” for out of state corporation
- Enter address information provided on all forms
- 1099 – circle “N” for no

Payment Address

- One Time Payment – leave this blank
- Question 3 – enter address and telephone number of your banking institution (branch level or main office; cannot be a P.O. box)

Section 5 – leave blank. The Medical Assistance Administration will complete this section.

Section 6 – circle “5” for vendor-business

Section 7 – circle “N” for Medical Corporation

MAA must receive “original” copies and signatures so they may be placed in your permanent file. Please review your completed for prior to submission and return all four (4) original forms together as soon as possible to:

ACS
P.O. Box 34761
Attn: Provider Enrollment
Washington, DC 20043

Questions – contact Provider Services at 202-906-8318



**GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
MEDICAL ASSISTANCE ADMINISTRATION**

2100 MARTIN LUTHER KING, JR. AVENUE, SE
SUITE 302
WASHINGTON, DC 20020

**MEDICAID PROVIDER
ACH/DIRECT DEPOSIT ENROLLMENT FORM**

SECTION 1

(All fields must be completed)

Name of Provider _____

Medicaid Provider Number (9-digit number assigned by ACS) _____

Federal Tax Identification Number _____

Bank Account Number _____

ABA/Routing Transit Number _____

Address _____ State _____ Zip _____

Point of Contact _____ Telephone Number _____

SECTION 2

(To be completed by the Chief Financial Officer or Authorized Representative)

CERTIFICATION

I confirm the identity of the above Medicaid provider, name, provider number, federal tax identification number, bank account number, and routing number. As a representative of the above named Medicaid Provider, I certify that the information is correct and the provider approves of the direct deposit option.

CFO or Authorized Representative _____
(print or type)

Signature of Representative _____

Telephone Number _____ Date _____

MAA Provider Enrollment Form
Provider Number Verification

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

Name		
Business name, if different from above		
Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other ▶	<input type="checkbox"/> Exempt from backup withholding	
Address (number, street, and apt. or suite no.)	Requester's name and address (optional)	
City, state, and ZIP code		
List account number(s) here (optional)		

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 2. For other entities, it is your employer identification number (EIN). If you do not have a number, see How to get a TIN on page 2.

Social security number								
or								
Employer identification number								

Note: If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.

Part II Certification

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
- I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 2.)

Sign Here	Signature of U.S. person ▶	Date ▶
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Purpose of Form

A person who is required to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to give your correct TIN to the person requesting it (the requester) and, when applicable, to:

- Certify the TIN you are giving is correct (or you are waiting for a number to be issued),
- Certify you are not subject to backup withholding, or
- Claim exemption from backup withholding if you are a U.S. exempt payee.

If you are a foreign person, use the appropriate Form W-8. See Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities.

Note: If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 30% of such payments after December 31, 2001 (29% after December 31, 2003). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

- You do not furnish your TIN to the requester, or
- You do not certify your TIN when required (see the Part II instructions on page 2 for details), or
- The IRS tells the requester that you furnished an incorrect TIN, or
- The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions on page 2 and the separate Instructions for the Requester of Form W-9.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.



**Government of the District of Columbia
Office of the Chief Financial Officer
Office of Finance and Treasury**

Direct Deposit Authorization Form
(Please read the reverse side carefully before completing this form)

**SECTION 1
(TO BE COMPLETED BY PAYEE)**

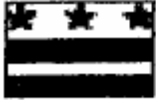
A. NAME OF PAYEE (last, first, middle initial)			B. ORGANIZATION CODE ID:	
ADDRESS (street, route, P.O. Box, APO/FPO)				
CITY	STATE	ZIP	C. NAME AND ADDRESS OF FINANCIAL INSTITUTION	
TELEPHONE NUMBER				
HOME	WORK			
NAME OF PERSON(S) ENTITLED TO PAYMENT				
SOCIAL SECURITY NUMBER				
GOVERNMENT AGENCY NAME			D. TYPE OF DEPOSITOR ACCOUNT o Checking o Savings	
GOVERNMENT AGENCY ADDRESS			E. DEPOSITOR ACCOUNT NUMBER	
			F. ABA/ROUTING TRANSIT NUMBER	

SECTION 2

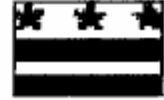
PAYEE/JOINT PAYEE CERTIFICATION I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form, I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.		JOINT ACCOUNT HOLDERS CERTIFICATION (optional) I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.	
SIGNATURE	DATE	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

**SECTION 3
(TO BE COMPLETED BY FINANCIAL INSTITUTION)**

FINANCIAL INSTITUTION CERTIFICATION I confirm the identity of the above named payee(s) and the account number, routing number and title. As a representative of the above named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above.			
PRINT OR TYPE REPRESENTATIVE'S NAME	SIGNATURE OF REPRESENTATIVE	TELEPHONE NUMBER	DATE



**GOVERNMENT OF THE DISTRICT
OF COLUMBIA**



<p>New Vendor <input type="checkbox"/> CHECK New Payment Address <input type="checkbox"/> ONLY New Business Address <input type="checkbox"/> ONE Deactivation <input type="checkbox"/></p>	<h2 style="margin: 0;">SUPPLIER/VENDOR INFORMATION FORM</h2>
<p>Business Entity Applicable <input type="checkbox"/> Y/N</p> <p>Supplier/Vendor Type: _____ (From Page 2)</p> <p>Ownership Code: _____ (From Page 2)</p>	<p>1. As information appears in official records: (ALL FIELDS MUST BE COMPLETED)</p> <p align="right">1099 Y/N <small>see 1099 requirements</small></p> <p>----- Federal Taxpayer ID Social Security Number</p> <p>Corporate Name: _____ Suite/Room: _____ Street: _____ City: _____ State: _____ Zip: _____ Telephone _____ Contact _____ Fax: _____</p>
<p>Individual Applicable <input type="checkbox"/> Y/N</p> <p>Supplier/Vendor Type: _____ (From Page 2)</p> <p>Ownership Code: _____ (From Page 2)</p>	<p>2. In an individual rather than a business entity: (ALL FIELDS MUST BE COMPLETED)</p> <p>----- Social Security Number</p> <p>Individual's Name: _____ Suite/Room: _____ Street: _____ City: _____ State: _____ Zip: _____ Telephone _____ Fax: _____</p>
<p>Payment Address</p> <p>One Time Payment: <input type="checkbox"/></p>	<p>3. To which all payments will be sent:</p> <p>Suite/Room: _____ Street: _____ City: _____ State: _____ Zip: _____ Telephone _____</p>
<p>Additional Payment Address</p>	<p>4. New additional payment address:</p> <p>Suite/Room: _____ Street: _____ City: _____ State: _____ Zip: _____ Telephone _____</p>
<p>Authorization</p> <p>Date Faxed <u> </u>/<u> </u>/<u> </u></p> <p>URGENT: Court Order: <input type="checkbox"/></p> <p>DCMR 1710 Emergency: <input type="checkbox"/></p>	<p>5. INFORMATION PROVIDED BY:</p> <p align="right">----- Print or Type Name of Requestor</p> <p>----- ----- ----- ----- Title Phone Fax 3 digit Agency Code</p> <p>----- ----- Agency Chief Contracting Officer (ACCO) Date</p> <p>----- ----- Agency Chief Financial Officer (ACFO) Date</p>

[OVER]

VENDOR INFORMATION FORM

Page 2 of 2

<p>FAX OR DELIVER TO: DIVISION OF VENDOR ENTRIES 810 FIRST STREET, N.E. SUITE 200 WASHINGTON, DC 20002 FAX: (202) 442-8217 For Assistance, call Division of Vendor Entries at (202) 442-8269</p>	
Vendor Type	<p>6. (Please circle one):</p> <ol style="list-style-type: none">1. Employee2. Federal Agency3. State Agency4. Local Government5. Vendor-business6. Vendor-Individual7. Other
Ownership Code	<p>7. (Please circle one):</p> <ol style="list-style-type: none">A. State CorporationC. Professional CorporationE. State EmployeeF. Financial InstitutionG. Government EntityI. Individual RecipientL. Local Small Disadvantage Business EnterprisesN. Medical CorporationO. Out of State CorporationP. Professional AssociationR. ForeignS. Sole OwnershipT. Partnership

FMS Form 710R (REV. 3/02)