

Form 0189 - Direct Deposit Enrollment for Providers, Vendors, and Contractors

Read instructions on page 2 prior to completing.

Section A - Payee Information

Payee Name: (Person or entity)

Provider Number: (Provider/ Vendor/ Employee OR#)

Tax ID Number: (SSN/ITIN or EIN)

SSN/ITIN

EIN

Medicaid ID Number: (MCD)

National Provider ID: (NPI)

Phone Number:

Email Address:

Mailing Address Line 1:

Mailing Address Line 2:

Section B - Request Purpose

New (start)

Change Account

Cancel (stop)

Section C - Financial Institution Information

Name of Bank/Credit Union:

Account Type:

Checking

Savings

Account Purpose:

Business

Personal

Bank Routing Number:

Bank Account Number:

**** AN ATTACHED COPY OF A PREPRINTED CHECK OR BANK VERIFICATION (BV) IS REQUIRED. ****

Are you attaching a check or BV?

Yes

No, I am cancelling deposits

Section D - Submission Information

I certify that I have read and understand the information contained in this form. This form authorizes direct deposit to a bank account. I acknowledge that the origination of transactions to the authorized account must comply with provisions of Oregon and US law. I certify that I am authorized to enter into this agreement as the account holder.

- **International transaction certification:** I certify that the entire amount of my direct deposit is NOT ultimately deposited into a financial institution outside the United States.
- **Recovery of funds deposited in error:** In the event an erroneous deposit occurs resulting in an overpayment, ODHS/OHA reserves the right to debit your account accordingly.

**** SIGNATURE MUST BE IN WET INK OR AN ADOBE CERTIFIED DIGITAL ID SIGNATURE. ****

Wet Ink or Adobe Certified Digital ID Signature:

Printed Name: (Of an Authorized Signer Only)

Title: (If company account)

Date:

Office Use Only:

OR-Kids

MMIS

SFMA

CBC/CEP

Original on file with ODHS

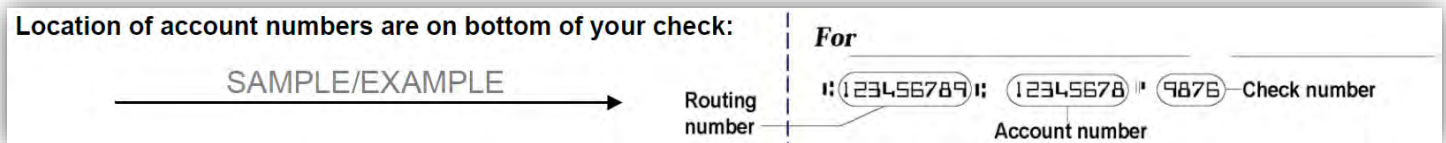
Agency Initials/Signature:

Date Processed:

Instructions for Form 0189 - Direct Deposit Enrollment for Providers, Vendors, and Contractors

This direct deposit request form *must be filled out completely*. Depending on the payment cycle, it may take 30 days to verify your account. Failure to include all information will void this authorization and it will be returned. **The following information must be included for your request to be processed:**

- ***Copy of voided preprinted check OR official bank verification letter.*** Attach Bank Verification (BV) document for all new or change requests. BV is not required to cancel.
 - Check or bank letter must be imprinted with the bank name, account holder name, address, routing number, and full account number.
 - Deposit slips, Web/App Portal screen prints, temporary checks, bank emails, and bank statements are not acceptable.
- Section A – ***Name and all contact information fields*** including provider/vendor number if known.
 - Provider name as listed with the agency (name and/or business name).
 - If you do not have a provider number yet, we will be unable to process your enrollment form as you will not yet be set up in our payment system.
 - List Medicaid (MCD) ID Number and/or National Provider Identifier (NPI) for Medicaid payments.
 - DO NOT list MCD or NPI if payments are for training classes, grants, loan repayments, or stipends.
 - NPI is not applicable for Home Care Workers (HCW) and Personal Support Workers (PSW)
- Section B – Select for new enrollment, or to change or cancel an existing enrollment.
- Section C – ***Include full routing and account number.*** Payee must be an authorized signer on the account. *Image below shows where to find this information on your check:*



- Section D – Signature: Form must be ***dated and have a written OR Adobe digital certified signature AND printed name*** of the authorized account holder (payee).

Send form and attachments to:

Mail: Department of Human Services/Oregon Health Authority
Office of Financial Services/Attn: EFT Coordinator
500 Summer St. NE, E-97
Salem, OR 97301-1080

Fax: 503-945-6860

Email: dhsaha.provdirdep@odhsaha.oregon.gov

This form may contain your personal information. If you return the form by email, there is some risk it could be intercepted by someone you did not send it to. If you are not sure how to send a secure email, consider using regular mail or fax.

Email for questions or call our message line – 503-945-6872. Include your Provider or Tax ID number and the date and how your form was submitted (mail, fax, email) in your message.

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact the Office of Communication Resources (OCR) at 503-378-3486, for TTY call 503-378-3523. We accept all relay calls.