ELECTRONIC FUNDS TRANSFER (EFT)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 661 (11-2024)

PRIVACY STATEMENT: The Privacy Act of 1974 (P.L. 93-579, Section 7) requires that the following information be provided when individuals are requested to disclose their social security number. Disclosure of the social security number is required pursuant to 26 CFR 301.6109-1 and is requested for the purpose of reporting tax information. Failure to disclose this information results in a $50 penalty under 26 CFR 301.6723-1 unless it is due to reasonable cause and not to willful neglect.

The Department of Health and Human Services require automatic direct deposit of payments.

Please fill this form out accurately and completely. All fields are required. For account verification, attach a copy of a voided check or letter from your financial institution. The letter must be on bank letterhead and provide the type of account (checking or savings), and routing numbers and be signed by a bank official. The name on the account must match the legal business name as reported to the IRS or the physician or individual practitioner. If you have questions regarding your account number or bank routing number, please contact your bank or financial institution for assistance in obtaining these numbers.

Once you are enrolled for electronic transfer of funds you will not receive a check or deposit slip with the Remittance Advice (R/A). Please inform your bookkeeping personnel of this to avoid unnecessary telephone calls to the department. The acronym "ACH" will appear in place of the check number in the upper left hand corner of the R/A indicating an automatic check deposit. Allow up to two billing cycles before payments are deposited into your chosen account. Until processing is complete, you will receive a paper check to the billing address on file.

If you have questions or need more information, contact Noridian Healthcare Solutions Email: NDMedicaidEnrollment@noridian.com

Staple voided check or letter from your financial institution here

I authorize THE DEPARTMENT OF HEALTH AND HUMAN SERVICES and the financial institution named below to initiate deposits to the checking or savings account listed. This authority will remain in effect until I notify the department in writing to cancel this authority, and allow the financial institution a reasonable amount of time to act upon the cancellation.

Name of Financial Institution		Telephone Number	
Street Address of Financial Institution	City	State	ZIP Code
Provider Name (the Legal Business Name, as reported to the IRS, must be listed)		Telephone Number	
Provider Address (service, billing or mailing address)	City	State	ZIP Code
Signature (authorized representative, managing employee, board member, or owner)			Date
PRINTED NAME OF PERSON SIGNING AND THEIR POSITION			
You **must** check one ☐ Checking ☐ Savings	Account Number	Financial Institutions Routing Number	
EIN/SSN	Medicaid Provider Number (Initial applications can leave this field blank)		

CONTACT INFORMATION FOR REQUESTOR

First Name	Last Name	Position
Telephone Number	Email Address	

Submit by securemail, fax, or mail to:

Fax: Providers may fax the required documentation and this form to 701-433-5956 ATTN: NDM Provider Enrollment

Email: NDMedicaidEnrollment@Noridian.com (please do not send EFT information, dates of birth, or Social Security Numbers by unsecured email)

Mailing Address:
Noridian Healthcare Solutions
Attn: ND Medicaid Provider Enrollment
PO Box 6055
Fargo, ND 58121-6055