Ohio | Office of Budget and Management

Mike DeWine, Governor
Jon Husted, Lt. Governor
Kimberly Murnieks, Director

# Electronic Funds Transfer (EFT)
# Payment Authorization Agreement for Direct Deposit

All sections must be completed (unless labeled as optional). If a field is not applicable, please enter N/A. Incomplete forms will be returned. All information must be legible.

## Section 1 - Type of Transaction

☐ Add ☐ Change/Update ☐ Inactivate

## Section 2 - Contact Information

Employer Identification Number (EIN) or Social Security Number (SSN): ☐☐☐☐☐☐☐☐☐

*(no dashes or spaces)*

Legal Business or Individual Name: _____

Business Name, Trade Name, Doing Business As: _____
*(If different than above)*

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Phone Number: _____

## Section 3 - State Agency Disbursing Payment

☐ Lottery ☐ OOD/PCA ☐ All other State of Ohio Agencies *(example: DODD)*

☐ Medicaid Provider

Provider # ☐☐☐☐☐☐☐

NPI # ☐☐☐☐☐☐☐☐☐☐

Assigning Authority ☐

## Section 4 - Prior Financial Information (change / update account)

Prior Financial Institution Name: _____

Account Type: ☐ Checking ☐ Savings

Prior Account Number: | | | | | | | | | | | | | | | | | |

*(Account Number must match account number on file)*

Prior Transit Routing / ABA Number: | | | | | | | | | |

*(Routing Number must match routing number on file)*

## Section 5 - New Financial Information (bank verification must be attached)

New Financial Institution Name: _____

Account Type: ☐ Checking ☐ Savings

New Account Number: | | | | | | | | | | | | | | | | | |

*(Account Number must match attached bank verification)*

New Transit Routing / ABA Number: | | | | | | | | | |

*(Routing Number must match attached bank verification)*

## Section 6 - Agreement

- Account changes must be reported to OBM Shared Services (OSS) thirty (30) days prior to the effective date.
- All EFT accounts are tied to an address in our system; a form is required for each address (if needed).
- The entity listed hereby authorizes the Ohio Office of Budget and Management (OBM) to initiate credit entries to its account in the financial institution identified above. Additionally, this form provides OBM the authority to debit any erroneous credit or transfers to the account in the amount of the transfer. This authority is to remain in effect until revoked by us in writing to OSS, a division of OBM.

☐ I have attached a copy of a current voided check or included a bank letter on bank letterhead signed by a bank representative.

☐ Medicaid PROVIDERS – I have ensured the Name, Address, TIN, NPI# & Provider Number matches the information in the MITS Medicaid Web Portal .

☐ I have printed and signed the form

## Section 7 - Sign and Date

Name: _____ Title: _____

Signature: _____ Date: _____

Handwritten signature is required.

### Submit to one of the following:

Email: Payee@Ohio.Gov
Fax: 1-614-485-1052
Mail: OBM Shared Services
Attn: Supplier Operations
P.O. Box 182880
Columbus, OH 43218-2880

### Questions? Need Help? Please Contact:

Phone: 1-877-OHIO-SS1 (1-877-644-6771)
1-614-338-4781
Website: OhioPays.Ohio.Gov
Email: obm.sharedservices@obm.Ohio.Gov

***NOTE:*** *This document contains sensitive information. Sending via non-secure channels, including email and fax, can be a potential security risk. Pursuant to 26 USC 6109, the state is required to collect TIN / EIN / SSN and to use the numbers in its annual report to the IRS on the amount the state has paid each supplier.*