



### ***DAKOTACARE EFT Enrollment Instructions***

#### ***Instructions for completing the EFT enrollment form***

- The EFT enrollment form begins on page 2, and ends on page 3.
- Please type or print legibly.
- Use only black or blue ink to complete the paper form.
- An electronic enrollment form can be accessed at <https://access.dakotacare.com>.
- Please allow 4 weeks for completion of the enrollment process, which includes pre-note verification. If after 4 weeks, you do not start receiving EFT payments, please contact Provider Relations at 1-800-325-5598.
- For questions regarding the paper or electronic enrollment process, please call Provider Relations at 1-800-325-5598.
- See Appendix A – Data Element Names and Descriptions on pages 4 and 5 for descriptions of each data element collected on the form.
- See Appendix B – Sample EFT Enrollment Bank Letter on page 6 for a sample of a bank letter that can be requested from your financial institution, in lieu of a voided check.

#### ***Manual Submission***

DAKOTACARE encourages electronic enrollment for more timely and accurate processing. If you are submitting a paper form, please send the form to the following address:

DAKOTACARE  
Attn: Provider Relations  
5300 S Broadband Lane  
Sioux Falls, SD 57108

#### ***Late/Missing Files***

EFT files that have not been received after 4 business days of the corresponding ERA file can be researched by calling Provider Relations at 1-800-325-5598.

#### ***CCD+ Reassociation Data***

If enrolled for 835 Electronic Remittance Advice (ERA), the provider must contact their financial institution to arrange for the delivery of the CORE-required Minimum CCD+ data elements needed for reassociation of the payment and the 835 ERA.



**DAKOTACARE EFT Enrollment Form**

**Provider Information (DEG1)**

Provider Name

**Provider Address**

Street

City  State/Province  Zip Code/Postal Code

**Provider Identifiers Information (DEG2)**

**Provider Identifiers**

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN): \_\_\_\_\_

National Provider Identifier (NPI): \_\_\_\_\_

**Provider Contact Information (DEG3)**

Provider Contact Name

Title

Telephone Number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Telephone Number Extension

Email Address

Fax Number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Financial Institution Information (DEG7)**

Financial Institution Name

**Financial Institution Address**

Street

City  State/Province  Zip Code/Postal Code

Financial Institution Routing Number

Type of Account at Financial Institution (e.g.: Checking, Savings)

Provider's Account Number with Financial Institution

Account Number Linkage to Provider Identifier (Select one)

Provider Tax Identification Number (TIN): \_\_\_\_\_

National Provider Identifier (NPI): \_\_\_\_\_

*Note: If enrolled for 835 Electronic Remittance Advice (ERA), the provider must contact their financial institution to arrange for the delivery of the CORE-required Minimum CCD+ data elements needed for reassociation of the payment and the 835 ERA.*



Authorization Agreement

5300 S Broadband Lane  
Sioux Falls, SD 57108  
1-800-325-5598  
[www.dakotacare.com](http://www.dakotacare.com)

Electronic Funds Transfer (EFT)

**Submission Information (DEG8)**

Reason for Submission (*Select one*)

- New Enrollment
- Change Enrollment
- Cancel Enrollment

Include with Enrollment Submission:

*(Please specify which item you are including with your enrollment. At least one of these items is required by DAKOTACARE to complete your EFT enrollment.)*

- Voided Check
- Bank Letter

Authorized Signature

Printed Title of Person Submitting Enrollment

Submission Date

This agreement is to remain in full force and effect until DAKOTACARE has received written notification of its termination in such time and in such manner as to afford DAKOTACARE and the depository a reasonable time to act.

Please return this form to: **DAKOTACARE**

Attn: Provider Relations  
5300 S Broadband Lane  
Sioux Falls, SD 57108



**Appendix A – Data Element Names and Descriptions**

<b>Data Element Name</b>	<b>Data Element Description</b>
<b>DEG1 – PROVIDER INFORMATION</b>	
Provider Name	Complete legal name of institution, corporate entity, practice or individual provider
Provider Address – Street	The number and street name where a person or organization can be found
Provider Address – City	City associated with provider address field
Provider Address –State/Province	ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country
Provider Address – ZIP Code/Postal Code	System of postal - zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities
<b>DEG2 – PROVIDER IDENTIFIERS INFORMATION</b>	
Provider Identifiers – Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity
Provider Identifiers – National Provider Identifier (NPI)	A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10 - position, intelligence - free numeric identifier (10 - digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions
<b>DEG3 – PROVIDER CONTACT INFORMATION</b>	
Provider Contact Name	Name of a contact in provider office for handling EFT issues
Provider Contact Name – Title	
Provider Contact Name – Telephone Number	Associated with contact person
Provider Contact Name – Telephone Number Extension	
Provider Contact Name – Email Address	An electronic mail address at which the health plan might contact the provider
Provider Contact Name – Fax Number	A number at which the provider can be sent facsimiles
<b>DEG7 - FINANCIAL INSTITUTION INFORMATION</b>	
Financial Institution Name	Official name of the provider’s financial institution
Financial Institution Address – Street	Street address associated with receiving depository financial institution name field
Financial Institution Address – City	City associated with receiving depository financial institution address field
Financial Institution Address – State/Province	ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country
Financial Institution Address – ZIP Code/ Postal Code	System of postal - zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities
Financial Institution Routing Number	A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited
<b>Data Element Name</b>	<b>Data Element Description</b>



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<b>DEG7 - FINANCIAL INSTITUTION INFORMATION (Continued)</b>	
Type of Account at Financial Institution	The type of account the provider will use to receive EFT payments, e.g., Checking, Saving
Provider's Account Number with Financial Institution	Provider's account number at the financial institution to which EFT payments are to be deposited
Account Number Linkage to Provider Identifier	Provider preference for grouping (bulking) claim payments – must match preference for v5010 X12 835 remittance advice
Account Number Linkage to Provider Identifier – Provider Tax Identification Number (TIN)	
Account Number Linkage to Provider Identifier – National Provider Identifier	
<b>DEG8 – SUBMISSION INFORMATION</b>	
Reason for Submission – New Enrollment	
Reason for Submission – Change Enrollment	
Reason for Submission – Cancel Enrollment	
Include with Enrollment Submission – Voided Check	A voided check is attached to provide confirmation of Identification/Account Numbers
Include with Enrollment Submission – Bank Letter	A letter on bank letterhead that formally certifies the account owners routing and account numbers
Authorized Signature	The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment
Authorized Signature – Printed Name of Person Submitting Enrollment	The printed name of the person signing the form
Submission Date	The date on which the enrollment is submitted
Requested EFT Start/Change/Cancel Date	The date on which the requested action is to begin



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Electronic Funds Transfer (EFT)

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**Appendix B – Sample EFT Enrollment Bank Letter**

Below is a sample bank letter that is sometimes used during the EFT enrollment process to validate the bank account information involved in the enrollment, in lieu of a voided check.

Sample Bank Letter, to be produced on company letterhead:

Month Day, Year

To Whom it May Concern,

This letter is to verify the following account information for *facility name*:

Name on account:  
Account number:  
ABA routing number:  
Account type:

Please contact me at the following number with any additional questions: xxx-xxx-xxxx.

Sincerely,

Signature  
Title  
Address