ELECTRONIC FUNDS TRANSFER (EFT)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 661 (1-2024)

Clear Fields

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 has the capability of automatic direct deposit of payments. If you are interested in utilizing this service, we will need additional information to assist in providing you with a prompt, accurate payment. An authorization for direct deposit is needed.

Please fill this form out accurately and completely. For account verification, attach a voided check, deposit slip, or documentation from your financial institution with both routing and account numbers. Send this to the address below. 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 have been 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.

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

Staple voided check, deposit slip, or document here

I authorize THE DEPARTMENT OF HEALTH AND HUMAN SERVICES and the financial institution named below to initiate deposits to the checking 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		Telephone Number	
Provider Address	City	State	ZIP Code
Signature			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	

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: NDP 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