

Provider Authorization of Claims Payments via Electronic Funds Transfer

This form is for providers to authorize the initiation of direct deposit of claims payments via electronic funds transfer (EFT) to a bank account or to change bank account information for an existing authorization. This form is only for providers; individual claimants who wish to establish direct deposit must use the Claimant Authorization of Claims Payments via Electronic Funds Transfer form, which is available at LTCFEDS.gov. Payments will only be made directly to providers when a claimant has assigned benefits to the provider. If no such assignment of benefits is in effect, any claims payments will be made directly to the claimant.

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I understand that I may revoke this authorization at any time by notifying FedPoint in writing at **FLTCIP**, **Attn: FedPoint**, **P.O. Box 797**, **Greenland**, **NH 03840-0797**. FedPoint requires notice of at least five business days in order to cancel this authorization. In the event I cancel direct deposit of claims payments, future claims payments will be made via paper check.

Note: A handwritten signature is required.
Signature (the signatory must be authorized to act on behalf of the provider)
(Required)
Printed name
Title
Phone number
Date signed / / (Required: mm/dd/yyyy)

Please return your completed form by email to **claimsinfo@ltcfeds.gov**, by fax to **1-866-513-2674**, or by mail to **FLTCIP**, **Attn: FedPoint**, **P.O. Box 797**, **Greenland**, **NH 03840-0797**.