

Georgia Department of Community Health
Banking Information for Electronic Transfer of Funds
For Payment of Hospital Provider Fee
Initial Electronic Transfer of Funds

**NOTE – The following information must be submitted on or before
August 24, 2010 in order for electronic payments to be available for the initial payment due
on September 30.**

About the hospital:

Hospital name: _____

Hospital address: _____

Medicaid identification number: _____

Taxpayer identification number: _____

(only for hospitals not enrolled in the Medicaid program)

About the contact person for your hospital:

Name: _____

Title: _____

Address: _____

E-mail address: _____

Telephone number: _____

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About the bank account that will be used for your provider fee payment:

Bank account number: _____
Bank routing (ABA) number: _____
Bank name and address: _____

Attach blank voided check or deposit slip to form:

Return completed Banking Information for Electronic Transfer of Funds forms (2 pages) and attachment

by fax to (877) 711-2262

or by mail or delivery to:

Ms. Pam Smith
Office of Financial Services
Department of Community Health
2 Peachtree Street, N.W. – 34th Floor
Atlanta, Georgia 30303-3159
Telephone No. (404) 463-8614

In order to avoid potential security risks, please do not submit the banking information form by e-mail.