UnitedHealthcare South Florida | Medicare Solutions

**March 31, 2017**

To: All Medica /Preferred Care Partners Participating Primary Care Physicians

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**Re: Capitation Payment Transition to Enterprise Cap (ECap)**

**Medica/Preferred Care Partners** is changing its capitation and payment platforms to Enterprise Capitation System (ECap) **tentatively effective August 1st, 2017.** This change requires completion of an Electronic Funds Transfer (EFT) form to establish Automated Clearing House (ACH) transfer. Any providers wishing to continue receiving electronic payments or those wanting to switch their capitation payments from checks to EFT must complete this form.

For current check providers, the transition to an ACH payment has several distinct advantages:

- Automatically receive access to funds on the day ACH transmission is received, i.e., the contractual due date of the capitation payment.

- Eliminate the need to have someone physically make a bank deposit.

To receive future payments electronically, please complete the attached ACH Authorization Agreement and submit per the instructions on top of the form.

- If a provider has the same Tax Identification Number (TIN) and is receiving capitation payments for both Medica and Preferred Care Partners, only one completed form is needed. The payments for both businesses will be paid via ACH unless indicated otherwise.

- If the TINs are different for Medica and Preferred Care Partners businesses, a separate form is needed per TIN. Be sure to indicate on the form whether the TIN is for Medica or Preferred Care Partners to eliminate a follow up phone call and any delay in the set up process.

- If the bank accounts are different for Medica and Preferred Care Partners businesses, a separate form is required for each bank account. Don't forget to specify which bank account belongs to which business.

Be sure to include a Voided Check or Bank Verification Letter that shows proof of the account name and number and be sure that an authorized signer on the account signs the ACH Authorization Agreement.

**Please note: the transition to ACH is contingent upon receipt of the completed authorization form by June 16, 2017 for the initial cap run on the new platform.**

Forms received after that date may not become effective until the following capitation cycle. United Healthcare will retain the completed agreement for our records.

If you have any questions or concerns regarding this correspondence please contact Medica/Preferred Care Partners Network Management Department by E-mail pcp-NetworkManagementServices@uhcsouthflorida.com or by phone 877-670-8432.

UnitedHealthcare
A UnitedHealth Group Company

# Capitation Authorization Agreement
# Electronic Funds Transfer (EFT) Payments

**After you review and complete this form, please fax or mail the form and a copy of a Voided Check or Bank Verification Letter to the following:**

**FAX (714) 784-3992 (preferred)**
**OR**
**Mail to:**
**UnitedHealthcare: Payment Operations Western Region, P.O. BOX 6100, Cypress, California 90630**
**If you have any questions, contact us at (877) 859-8354**

I hereby authorize UnitedHealthcare hereinafter called **Company**, to initiate bank deposits using ACH credits to the account and depository named below, hereinafter called **Bank**, to credit the same such account.

**This section is to be completed by the entity receiving payment.**

| | | | |
|---|---|---|---|
| Organization Name | Tax ID Number | | |
| Contact Name<br><br>Contact Phone number | Authorization request type (check one):<br>☐ New EFT Authorization<br>☐ Revision to Current Authorization (i.e. account or bank changes)<br>☐ EFT Termination Request | | |
| Street Address | City | State | Zip Code |
| Bank Name | Bank Contact | | |
| Bank Phone | | | |
| Account Title as filed at Bank | | | |
| Bank account type: Checking or Savings | | | |
| Bank Routing Number, 9-digits | Bank Account Number | | |
| Additional banking instructions, if applicable | | | |

This authority is to remain in effect until **Company** has received written notification from us of its termination in such time and such manner as to afford **Company** a reasonable opportunity to act on it. We recognize that changes to the banking information must be communicated immediately

**I have verified with my bank that all of the information above is complete and correct.**

**Authorized Signature:** _____ **Date:** _____

**Print Name & Title:** _____
(Signature certifies that the information provided herein is true and accurate in all respects and the he/she has been duly authorized by all necessary and appropriate action, where applicable, to execute this agreement on behalf of the above mentioned Office Name to form a legally binding contract.)

| **For Internal Use only: Payment Operations Western Region** | |
|---|---|
| Disb. Bank: _____<br>Disb. Account: _____<br>A/P Approval: _____ Date: _____ | Vendor/Payee Identifier:<br><br>_____ |