



UnitedHealthcare South Florida | Medicare Solutions

July 28, 2017

To: All Medica /Preferred Care Partners Participating Primary Care Physicians – **2nd Notice**

Re: Capitation Payment Transition to Enterprise Cap (ECap)

Medica/Preferred Care Partners is changing its capitation and payment platforms to Enterprise Capitation System (ECap) **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.



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

For more information on how to access, read and use the Capitation Reports you will be receiving on a monthly basis – you may download a copy of the Provider Manual Capitation Report Training on our websites as follows.

<http://www.medicaplans.com/en/physicians-and-providers/physicians-and-providers.aspx>

<http://www.mypreferredprovider.com/medicare/en/home.aspx>

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.

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	Authorization request type (check one):		
Contact Phone number	<input type="checkbox"/> New EFT Authorization <input type="checkbox"/> Revision to Current Authorization (i.e. account or bank changes) <input type="checkbox"/> 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: _____ Disb. Account: _____ A/P Approval: _____ Date: _____	Vendor/Payee Identifier: _____