# Revision History – Version 7

<table>
<thead>
<tr>
<th>Title of Section &amp; Revisions/Changes Description (since last version)</th>
<th>Link to Affected Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requirements: Updated language</td>
<td>Section 2.2</td>
</tr>
<tr>
<td>Completing and Submitting Form CMS-588: Updated language</td>
<td>Section 2.1</td>
</tr>
<tr>
<td>Appendix A, Form CMS-588 Cover Sheet: Updated language</td>
<td>Appendix A</td>
</tr>
<tr>
<td>Added Appendices</td>
<td>Appendix B; Appendix C; Appendix D</td>
</tr>
<tr>
<td>• Sample Form CMS-588 Cover Sheet</td>
<td></td>
</tr>
<tr>
<td>• Sample Form CMS-588</td>
<td></td>
</tr>
<tr>
<td>• Sample Financial Institution Letter and Voided Check</td>
<td></td>
</tr>
</tbody>
</table>
# Table of Contents

1. **Background** .......................................................................................................................... 1

2. **Requirements** .................................................................................................................... 1
   2.1 Completing And Submitting Form CMS-588 ............................................................... 2
   2.2 Form CMS-588 Updates ............................................................................................. 5

3. **Form CMS-588 Revalidation and Evaluation** ................................................................... 6
   3.1 Form CMS-588 Revalidation ...................................................................................... 6
   3.2 Form CMS-588 Evaluation ......................................................................................... 7

4. **Contact Us** ........................................................................................................................ 8

Appendix A: Form CMS-588 Cover Sheet .................................................................................. 9
   Form CMS-588 Request Type (Select Only One Request Type) ........................................ 9

Appendix B: Sample Form CMS-588 Cover Sheet ..................................................................... 10
   Form CMS-588 Request Type (Select Only One Request Type) ....................................... 10

Appendix C: Sample Form CMS-588 ........................................................................................ 11

Appendix D: Sample Financial Institution Letter and Voided Check ...................................... 14
1 Background

Each Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organization (ACO) must have an active checking account and must submit a completed Electronic Funds Transfer (EFT) Authorization Agreement (Form CMS-588) to the Centers for Medicare & Medicaid Services (CMS). CMS uses the banking information, business address, and taxpayer identification number (TIN) provided on this form to establish vendor accounts for ACOs in the Healthcare Integrated General Ledger Accounting System (HIGLAS). HIGLAS is a payment system that works with the U.S. Department of the Treasury and deposits funds through EFTs to ACO vendor accounts. CMS deposits any shared savings payments, if earned, to the banking account designated on Form CMS-588.

2 Requirements

Each Shared Savings Program ACO must have an active checking account and submit Form CMS-588, regardless of the ACO’s track.

1. Prior to completing Form CMS-588, an ACO must establish a checking account using the ACO’s legal entity name and the TIN the ACO established with the Internal Revenue Service (IRS) and used to establish the ACO with the Shared Savings Program. The ACO must have an active checking account that CMS has successfully validated to receive any earned shared savings payments. CMS validates the banking information before it makes EFT deposits into the checking account listed on Form CMS-588. In addition, for ACOs that receive shared savings payments, CMS sends an IRS Form 1099 to the address provided on Form CMS-588.

2. Form CMS-588 is required as part of an ACO’s Shared Savings Program application. ACOs must submit the Form CMS-588 cover sheet (Appendix A) with Form CMS-588. ACOs must also include supporting financial documentation (e.g., a voided, pre-printed check or a signed letter from the financial institution) that validates the checking account included on the form. CMS considers submissions that do not include Form CMS-588, a cover sheet, and required supporting financial documentation to be incomplete and will not process them.

TIP FOR SUCCESS

The checking account requirement for CMS to pay shared savings is separate from the repayment mechanism requirement for ACOs participating in a two-sided (shared savings and losses) model. An ACO participating in a two-sided model must establish an adequate repayment mechanism to pay CMS back for shared losses, if incurred.

- Repayment Mechanism Arrangements Guidance
3. An ACO must update its banking information on file with CMS whenever any ACO information submitted on Form CMS-588 changes (refer to Section 2.2). An update to the Form CMS-588 is not required if the financial institution physical address has changed.

**TIP FOR SUCCESS**

You must submit Form CMS-588, the accompanying cover sheet, and the required supporting financial documentation to participate in the Shared Savings Program, even if you already receive EFT payments from Medicare. Payments for the Shared Savings Program are made through a different payment system than that used for other Medicare payments and have no effect on EFTs set up for other Medicare payments.

### 2.1 COMPLETING AND SUBMITTING FORM CMS-588

CMS will not accept forms listed under an ACO participant’s TIN or parent/chain organization’s name. The ACO legal entity name and ACO TIN on Form CMS-588 must match the ACO’s information in the ACO Management System (ACO-MS). For example, please be certain to include any name extensions, such as “LLC” or “Incorporated,” when completing the form, if applicable. Please make certain an entry is provided for each item on Form CMS-588. CMS does not accept partially completed forms.

**FOR RENEWAL APPLICANTS ONLY:** Your ACO does not need to submit a new Form CMS-588 if the ACO legal entity name, ACO TIN, address, financial institution information, contact person, or authorized/delegated official have not changed.

Step 1: Download **Form CMS-588**

Step 2: Complete or check the following entries:

- **Part I: Reason for Submission**
  - **Initial applicants:**
    - On the Form CMS-588, check “New EFT Enrollment” and check “Individual” or “Group.”
    - On the Form CMS-588 cover sheet ([Appendix A](#)), check “New EFT Enrollment.”
  - **Currently participating ACOs and renewal applicants:**
    - On the Form CMS-588, check “Change to Current EFT Enrollment.”
    - On the Form CMS-588 cover sheet ([Appendix A](#)), check “Change to
Current EFT Enrollment.”

◦ Revalidation:
  - On the Form CMS-588, check “Revalidation.”

### Part II: Account Holder Information

◦ Provide entries for all items. All account holder information must match ACO-MS.
  - ACO legal entity name
  - ACO address
  - ACO TIN (nine digits only)
    - Indicate TIN type (Social Security Number (SSN) or Employer Identification Number (EIN))
  - National Provider Identifier (NPI) is not required if an ACO is not Medicare-enrolled. Please note that the ACO TIN is not required to be Medicare-enrolled. However, if the ACO TIN is Medicare-enrolled, enter the Medicare Identification Number. There is limited space, so include a separate list with the other documentation.

### Part III: Financial Institution Information

◦ Provide entries for all items:
  - All fields in this section are required, except the financial institution’s contact person field. While it is optional, CMS recommends including a point of contact at the financial institution that CMS can contact in the event of issues with payments.

◦ Provide supporting documentation that confirms the checking account information provided on Form CMS-588.
  - The supporting documentation can be either a voided, pre-printed check or a signed letter from the financial institution. Form CMS-588 cannot be processed without the supporting documentation, so make sure to include it whenever you submit Form CMS-588 to CMS. The ACO legal entity name on the supporting documentation must match ACO-MS and Form CMS-588.
  - If you are submitting a voided, pre-printed check, please note that CMS does not accept starter checks. The ACO legal entity name must be printed on the...
check and must match ACO-MS. If you only have starter checks, obtain a signed letter from your financial institution.

- If you are submitting a signed letter from your financial institution, it must include your ACO’s checking account and routing numbers. Include the following information in the letter and confirm the information is consistent with the entries on Form CMS-588:
  - ACO legal entity name as the account holder
  - ACO TIN (nine digits only)
  - Bank official’s name and signature
  - Checking account number
  - Electronic routing transit number

**Part IV: Contact Person**

- Enter the name of a contact who can discuss the form if CMS has questions.

**Part V: Authorization**

- [*Form CMS-588*](#) must be signed by a person with the authority to legally bind the ACO. Only one person can sign the form. CMS encourages you to have one of the following ACO-MS contacts sign the form:
  - ACO Executive
  - Financial Contact
  - Authorized to Sign (primary or secondary)

- An ACO must submit Form CMS-588 documentation in the form of a PDF scan of a wet signature. The handwritten signature line must contain the authorized/delegated official’s name, title, phone number, and email address. CMS may request the complete, original Form CMS-588 documentation executed by wet, handwritten signature.

**Top Right Corner of Form CMS-588 and Each Page of Supporting Documentation:**

- The Office of Financial Management (OFM) processes Form CMS-588 and makes payments to ACOs that earn shared savings. To assist OFM with the processing of Form CMS-588, please indicate the ACO's ACO ID number (Axxxx) and the ACO’s tax status (Profit – “P” or Non-Profit – “NP”) in the blank

---

**TIP FOR SUCCESS**

CMS recommends the contact person be identified as an ACO contact in ACO-MS.
area on the top right corner of the first page of Form CMS-588. CMS provided your ACO with an ACO ID (Axxxx) during the application process.

Step 3: Fill out the Form CMS-588 Cover Sheet

This form (Appendix A) must be included with your ACO’s Form CMS-588. Complete all information, as applicable, in each of the fields.

Complete the “Reason for Revision to Existing Form CMS-588” section only if you are revising an existing Form CMS-588 that CMS has on file.

Step 4: Upload the Form CMS-588, the Form CMS-588 Cover Sheet, and the Form CMS-588 supporting documentation to ACO-MS

Upload all required Form CMS-588 documentation to the Documents tab, under the Form CMS-588 field within ACO-MS.

### TIP FOR SUCCESS

Form CMS-588 contains extra digit fields to responses such as TIN, account number, and/or routing number. Remember to write out the appropriate nine-digit TIN, account number, and/or routing number, excluding hyphens. Leave any unnecessary additional spaces blank.

### 2.2 FORM CMS-588 UPDATES

If an ACO needs to update its form or change any of the following information on the existing Form CMS-588, it must complete and upload a new Form CMS-588 to ACO-MS. If an update to the Form CMS-588 documentation is required outside of an application or change request review cycle, ACOs must complete and send the new Form CMS-588 to the Shared Savings Program Mailbox (SharedSavingsProgram@cms.hhs.gov) in an encrypted email. The email must include:

- ACO legal entity name
- ACO TIN
- ACO address
- Financial institution information
- Contact person
- Authorized/delegated official

All changes must appear in ACO-MS before the ACO can revise its Form CMS-588. If an ACO requests a change to its ACO legal entity name and/or ACO TIN, CMS must
notify the ACO once the change is effective and provide instructions on how and when to update the banking form.

**Complete the following steps to update your Form CMS-588:**


2. Complete the entries on the form and provide the supporting documentation following the instructions in Section 2.1 of this document.

3. On the Form CMS-588 cover sheet (Appendix A), check “Change to Current EFT Enrollment.”

4. Submit the Form CMS-588, the cover sheet, and the supporting documentation materials in one of two ways: If submitting during the application and change request cycle, please upload to the Documents tab under the Form CMS-588 field within ACO-MS; if submitting outside of these cycles, please send an encrypted email to the Shared Savings Program Mailbox at SharedSavingsProgram@cms.hhs.gov.

### 3 Form CMS-588 Revalidation and Evaluation

#### 3.1 FORM CMS-588 REVALIDATION

An ACO may verify Form CMS-588 information at any time with CMS. For security reasons, CMS cannot send you a copy of your form. However, an ACO can upload a copy of its form along with the supporting documentation for OFM to verify the information on file. Please take the following actions when submitting your request:

- Complete a new Form CMS-588 with your current banking information or a copy of the previously submitted form.
- Include your voided, pre-printed check or a signed letter from your financial institution as supporting documentation. OFM will not verify the request without both the completed form and supporting documentation.
- On the Form CMS-588 cover sheet (Appendix A), check “Revalidation.”
- Upload Form CMS-588, the cover sheet, and supporting documentation materials to ACO-MS. If revalidation of the Form CMS-588 occurs outside of an application or change request cycle, send an encrypted email to the Shared Savings Program Mailbox at SharedSavingsProgram@cms.hhs.gov.
- Once approval of the Form CMS-588, the cover sheet, and the supporting documentation is complete, your ACO will receive feedback from ACO-MS or the
3.2 FORM CMS-588 EVALUATION

During the application or change request cycle, an ACO must electronically upload the Form CMS-588, the cover sheet, and supporting documentation to start the review process in ACO-MS. CMS reviews Form CMS-588 and supporting documentation to confirm that it matches the information on file in ACO-MS. For example, CMS ensures that the ACO legal entity name and ACO TIN submitted on Form CMS-588 are the same as that in ACO-MS. CMS staff will identify mismatched information or any discrepancies during the review process and contact you for corrections. The ACO must correct any mismatched information and address any discrepancies.

CMS processes Form CMS-588 only after all discrepancies are resolved. If an ACO submits the Form CMS-588 via the Shared Savings Program Mailbox (SharedSavingsProgram@cms.hhs.gov) outside of an application or change request review cycle, the same review process will apply.

Prior to making any earned shared savings payments, CMS conducts a prenote authorization on the ACO accounts. A prenote is a test transaction a banking institution uses to make sure an account is open and the provided account number information is valid before setting up an automated clearing house (ACH) transfer. CMS will contact you if the prenote fails to validate your account.

There are several reasons for a prenote failure, including:

- A discrepancy with an ACO legal entity name and/or ACO TIN;
- Inaccurate account information; and/or
- A closed account.

Please note that financial institutions may require a deposit to the checking account to maintain active account status. CMS encourages ACOs to communicate with financial institutions to ensure the checking account utilized within the Form CMS-588 remains active. If you are a currently participating ACO, earned shared savings payments may be delayed if issues are not resolved before the OFM payment cycle release date.

TIP FOR SUCCESS

ACOs unsure if their banking information with CMS is correct should verify their banking information prior to the release of the performance year financial reconciliation results.
4 Contact Us

ACOs that have uploaded documentation for review to ACO-MS will receive feedback via ACO-MS.

Please submit questions to the following email address:

SharedSavingsProgram@cms.hhs.gov
Appendix A: Form CMS-588 Cover Sheet

Form CMS-588 Request Type (Select Only One Request Type)

☐ New EFT Enrollment ☐ Change to Current EFT Enrollment ☐ Revalidation

ACO LEGAL ENTITY INFORMATION

ACO ID # (A+4 digits): Click or tap here to enter text.
ACO Legal Entity Name: Click or tap here to enter text.
ACO Taxpayer Identification Number (TIN): Click or tap here to enter text.
ACO Tax Status: ☐ For-profit ☐ Nonprofit

REASON FOR REVISION TO EXISTING FORM CMS-588

Complete only if you are revising an existing Form CMS-588.
(Select all revisions that apply)

☐ Name ☐ Contact Person
☐ TIN ☐ Authorization - Signature
☐ Financial Institution ☐ Other Information

UPLOAD BANKING INFORMATION TO ACO-MS

During the application cycle or change request cycle, upload the following materials to the Form CMS-588 field, located within the Documents tab in the ACO Management System (ACO-MS). Outside the cycle, please send an encrypted email to the Shared Savings Program mailbox at SharedSavingsProgram@cms.hhs.gov.

MATERIALS

- Signed Form CMS-588
- Form CMS-588 cover sheet
- Supporting financial documentation in the form of a bank letter or voided, pre-printed check
Appendix B: Sample Form CMS-588 Cover Sheet

FORM CMS-588 REQUEST TYPE (SELECT ONLY ONE REQUEST TYPE)

☒ New EFT Enrollment  ☐ Change to Current EFT  ☐ Revalidation
Enrollment

ACO LEGAL ENTITY INFORMATION

ACO ID # (A+4 digits): A1234
ACO Legal Entity Name: 5 Star ACO, LLC
ACO Taxpayer Identification Number (TIN): 123456789

☐ For-profit  ☒ Nonprofit

REASON FOR REVISION TO EXISTING FORM CMS-588

Complete only if you are revising an existing Form CMS-588.
(Select all revisions that apply)

☐ Name  ☐ Contact Person
☐ TIN  ☐ Authorization - Signature
☐ Financial Institution  ☐ Other Information

UPLOAD BANKING INFORMATION TO ACO-MS

During the application cycle or change request cycle, upload the following materials to the Form CMS-588 field, located within the Documents tab in the ACO Management System (ACO-MS). Outside the cycle, please send an encrypted email to the Shared Savings Program mailbox at SharedSavingsProgram@cms.hhs.gov.

MATERIALS

- Signed Form CMS-588
- Form CMS-588 cover sheet
- Supporting financial documentation in the form of a bank letter or voided, pre-printed check
Appendix C: Sample Form CMS-588

INSTRUCTIONS FOR COMPLETING THE EFT AUTHORIZATION AGREEMENT

All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicare direct deposits are made.

PART I: REASON FOR SUBMISSION
Indicate your reason for completing this form by checking the appropriate box: New EFT enrollment or change to your EFT enrollment account information. If you are authorizing EFT payments to the home office of a chain organization of which you are a member, you must attach a letter authorizing the contractor to make payment due the provider of service to the account maintained by the home office of the chain organization. The letter must be signed by an authorized official of the provider of service and an authorized official of the chain home office.

NOTE: If you have had either a change of ownership or change of practice location, you must submit a change of information (using the Medicare enrollment application) to the Medicare contractor that services your geographical area(s) prior to or accompanying this EFT authorization agreement submission.

PART II: ACCOUNT HOLDER INFORMATION
- Enter the provider/supplier’s legal business name or the name of the physician or individual practitioner, as reported to the Internal Revenue Service (IRS). The account to which EFT payments made must bear the name of the physician or individual practitioner, or the legal business name of the person or entity enrolled with Medicare.

NOTE: Providers/suppliers must report the legal business name provided on the IRS CP-575 form.
- Enter the chain organization’s name or the home office legal business name if different from the chain organization name.

NOTE: Providers/suppliers must report the legal business name provided on the IRS CP-575 form.
- Enter the account holder’s street address.
- Enter the account holder’s city, state, and zip code.
- Enter the tax identification number as reported to the IRS. If the business is a group, organization or corporation, provide the Federal employer identification number. If enrolling as an individual provide your Social Security Number.
- Enter the 10 digit NPI number. The NPI is required to process this form.
- If issued, enter the Medicare identification number assigned by a Medicare Administrative Contractor (MAC). If you are not enrolled in Medicare, leave this field blank. If more than one Medicare identification number is attached to this NPI, include the Medicare identification numbers on this form. NOTE: Institutional providers enter only ONE Medicare Identification Number (if issued).

PART III: FINANCIAL INSTITUTION INFORMATION
- Enter your Financial Institution's name (this is the name of the bank or qualifying depository that will receive the funds).

NOTE: The account name to which EFT payments will be paid is to the name submitted on Part II of this form.
- Enter the financial institution’s street address.
- Enter the financial institution’s city or town, state or province, and zip/postal code.
- Enter the bank or financial institutional telephone number and contact person's name.
- Enter the bank or financial institutional nine-digit routing number, including applicable leading zeros.
- Enter the provider/supplier's account number with the financial institution, including applicable leading zeros. Select the account type.

NOTE: Supporting bank documents must be in the provider/supplier/entiy's legal business name only.
- If you do not submit this information, your EFT authorization agreement will be returned without further processing.

PART IV: CONTACT PERSON
- Enter the name and title of a contact person who can answer questions about the information submitted on this CMS-588 form.
- Enter the contact person’s telephone number. Enter the contact person’s e-mail address.

PART V: AUTHORIZATION
By your signature on this form you are certifying that the account is drawn in the Name of the Physician or Individual Practitioner, or the Legal Business Name of the person or entity. The person or entity has sole control of the account to which EFT deposits are made in accordance with all applicable Medicare regulations and instructions. All arrangements between the Financial Institution and the said person or entity are in accordance with all applicable Medicare regulations and instructions with the effective date of the EFT authorization. You must notify CMS regarding any changes in the account in sufficient time to allow the contractor and the Financial Institution to act on the changes.

The EFT authorization form must be signed and dated by the same Authorized Representative or a Delegated Official named on the CMS-855 Medicare enrollment application which the Medicare contractor has on file. Include a telephone number where the Authorized Representative or Delegated Official can be contacted.

Mail, upload, or email this form to the Medicare contractor that services your geographical area. An EFT authorization form must be submitted for each Medicare contractor to whom you submit claims for Medicare payment. To locate the mailing address for your Medicare Administrative Contractor fee-for-service contractor, go to: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/
ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

PART I: REASON FOR SUBMISSION

Reason for Submission:
☒ New EFT Enrollment
☐ Group
☐ Change to Current EFT Enrollment (e.g. account or bank changes)
☐ Revocation
☐ Check here if EFT payment is being made to the Home Office of the Chain Organization (Attach letter Authorizing EFT payment to Chain Home Office)

PART II: ACCOUNT Holder INFORMATION

Provider/Surgeon Legal Business Name (if Individual, please provide first name, middle initial, last name, and suffix)
5 STAR ACO, LLC

Chain Organization Name or Home Office Legal Business Name (if different from Chain Organization Name)

Account Holder’s Street Address
800 Your Street

Account Holder’s City
Anytown

Account Holder’s State
NJ

Account Holder’s Zip Code
00000

Tax Identification Number (TIN)

Designate TIN:
SSN (enrolling as an individual) OR EIN (enrolling as a group/organization/corporation)

National Provider Identifier Number (NPI)

Medicare Identification Number (If issued)

Medicare Identification Number (If issued)

PART III: FINANCIAL INSTITUTION INFORMATION

Financial Institution's Name
Your Banker Institution

Financial Institution's Street Address
111 Bank Lane

Financial Institution’s City/Town
Moneyville

Financial Institution’s State/Province
NY

Financial Institution’s Zip Postal Code
00000

Financial Institution’s Telephone Number (Optional)
222-2222

Financial Institution’s Contact Person (Optional)
John Doe Banker

Financial Institution Routing Number (must be 9 digits)

Type of Account (Check One)
☒ Checking Account ☐ Savings Account

Provider/Surgeon’s Account Number with Financial Institution (Include all zeros)

Please include a confirmation of account information on bank letterhead or a voided check. When submitting the documentation, it should contain the name on the account, electronic routing transit number, account number and type. If submitting bank letterhead, the bank officer’s name and signature is also required. This information will be used to verify your account number. NOTE: Starter checks are not acceptable for EFT confirmations.

PLEASE NOTE: In accordance with section 1104 of the Affordable Care Act, enrollment of electronic fund transfer (EFT) is for electronic fund transfer authorization only. EFT enrollment does not constitute enrollment as a provider or supplier in the Medicare program.
PART IV: CONTACT PERSON

| This is the person we will contact for any questions regarding this EFT. |
|-------------------------------------------------|-------------------------------------------------|
| Contact Person’s Name                        | Contact Person’s Title                         |
| Your ACO Contact                              | Your ACO Contact Title                         |
| Contact Person’s Telephone Number 222-2222    | Contact Person’s E-mail Address                |
|                                               | acocontact@jacksample.com                       |

PART V: AUTHORIZATION

I hereby authorize the Centers for Medicare & Medicaid Services (CMS) to initiate credit entries, and in accordance with 31 CFR part 210.6(f) initiate adjustments for any duplicate or erroneous entries made in error to the account indicated above. I hereby authorize the financial institution/bank named above to credit and/or debit the same to such account. CMS may assign its rights and obligations under this agreement to CMS’ designated Medicare Administrative Contractor (MAC). CMS may change its designated contractor at CMS’ discretion.

If payment is being made to an account controlled by a Chain Home Office, the Provider of Services hereby acknowledges that payment to the Chain Office under these circumstances is still considered payment to the Provider, and the Provider authorizes the forwarding of Medicare payments to the Chain Home Office.

If the account is drawn in the Physician’s or Individual Practitioner’s Name, or the Legal Business Name of the Provider/Supplier, the said Provider/Supplier certifies that he/she has sole control of the account referenced above, and certifies that all arrangements between the Financial Institution and the said Provider/Supplier are in accordance with all applicable Medicare regulations and instructions.

This authorization agreement is effective as of the signature date below and is to remain in full force and effect until CMS has received written notification from me of its termination in such time and such manner as to afford CMS and the Financial Institution a reasonable opportunity to act on it. CMS will continue to send the direct deposit to the Financial Institution indicated above until notified by me that I wish to change the Financial Institution receiving the direct deposit. If my Financial Institution information changes, I agree to submit to CMS an updated EFT Authorization Agreement.

SIGNATURE LINE

<table>
<thead>
<tr>
<th>Authorized/Delegated Official Name (Print)</th>
<th>Authorized/Delegated Official Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jack Exec</td>
<td>(222) 222-2222</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Authorized/Delegated Official Title</th>
<th>Authorized/Delegated Official E-mail Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACO Executive</td>
<td><a href="mailto:jackexec@jacksample.com">jackexec@jacksample.com</a></td>
</tr>
</tbody>
</table>

Authorized/Delegated Official Signature (Note: Must be signed and dated to process.) Date 1/01/01

PRIVACY ACT ADVISORY STATEMENT

Sections 1842, 1862(b) and 1874 of title XVIII of the Social Security Act authorize the collection of this information. The purpose of collecting this information is to authorize electronic funds transfers.

Per 42 CFR 424.510(e)(1), providers and suppliers are required to receive electronic funds transfer (EFT) at the time of enrollment, revalidation, change of Medicare contractors or submission of an enrollment change request; and (2) submit the CMS-588 form to receive Medicare payment via electronic funds transfer.

The information collected will be entered into system No. 09-70-0501, titled “Carrier Medicare Claims Records,” and No. 09-70-0503, titled “Intermediary Medicare Claims Records” published in the Federal Register Privacy Act Issuances, 1991 Comp. Vol. 1, pages 419 and 424, or as updated and republished. Disclosures of information from this system can be found in this notice.

You should be aware that P.L. 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government, under certain circumstances, to verify the information you provide by way of computer matches.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0626. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. DO NOT MAIL THIS FORM TO THIS ADDRESS. MAILING YOUR APPLICATION TO THIS ADDRESS WILL SIGNIFICANTLY DELAY PROCESSING.
Appendix D: Sample Financial Institution Letter and Voided Check

December 17, 2021

5 STAR ACO, LLC
800 Your Street
Anytown, NJ 00000
Ref: Bank Confirmation Letter

To Whom It May Concern:

5 STAR ACO, LLC is a customer of YourBanker Institution. We are verifying the Account Name, Account Number, SWIFT BIC and Domestic ABA Routing and Transit Number of the following account:

Account Name: 5 STAR ACO, LLC
Checking Account Number: 1000000000001
Domestic ABA Routing: 000000000
ACO Tax Identification Number: (123456789)
Institution Name: YourBanker Institution
Institution Address: 111 Bank Lane Moneyville, NY 00000

Please call me if you have any questions. Thank you for your business and the opportunity to serve you.

Sincerely,

[Signature]

[Name]

[Phone Number] (222) 222-2222
[Email] Yourbanker@localbank.com

Client Service Sr. Associate
Your Bank
111 Bank Lane
Moneyville, NY 00000