

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

- In accordance with section 1104 of the Affordable Care Act, enrollment of electronic fund transfer (EFT) is for electronic fund transfer authorization only and doesn't constitute enrollment as a provider or supplier in the Medicare program.
- All EFT requests must be verified by the qualifying financial institution before any Medicare direct deposits are made.
- If you've changed ownership or practice location, you must use the Medicare enrollment application to submit a change of information to the Medicare contractor that serves your geographical area before you fill out this EFT authorization agreement.

I. REASON FOR SUBMISSION

- ☐ **New EFT Enrollment** ☐ **Change to Current EFT Enrollment** ☐ **Revalidation**
☐ Individual ☐ Organization (like business name or bank changes)
- ☐ Check here if EFT payment is being made to a Chain Home Office. You must attach a letter authorizing EFT payment to Chain Home Office, signed by authorized officials of both the service provider and the home office.

II. ACCOUNT HOLDER INFORMATION

Provider/Supplier Legal Business Name as reported on the IRS CP-575 form (If an individual, list first name, middle initial, last name, suffix)

Chain Organization Name or Home Office Legal Business Name (if different from Chain Organization Name)	Chain Home Office ID
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Account Holder Street Address

Account Holder City	Account Holder State	Account Holder ZIP Code
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Tax Identification Number (TIN) 	Designate TIN: ☐ SSN (enrolling as an individual) OR ☐ EIN (enrolling as a group/organization/corporation)
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National Provider Identifier Number (NPI) 	Medicare Identification Number (if issued)
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III. FINANCIAL INSTITUTION INFORMATION

Confirm the account information below by attaching bank letterhead or a voided check. Document should show the name on the account, electronic routing transit number, account number and type. If submitting bank letterhead, the bank officer's name and signature are required. Supporting bank documents must be in the provider's/supplier's/entity's legal business name. If a "doing business as" name is listed, it must appear after the legal business name. Starter checks are not acceptable for EFT confirmations. The bank account can't be a joint account, financial technology company, e-trade account, money market account, etc.

Financial Institution Name

Financial Institution Street Address

Financial Institution City	Financial Institution State/Province	Financial Institution ZIP Code
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Financial Institution Phone	Financial Institution Contact Person
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Financial Institution Routing Transit Number (must be 9 digits)

Provider's/Supplier's Depositor Account Number with Financial Institution (include all zeroes) 	Type of Account (select one) ☐ Checking Account ☐ Savings Account
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IV. CONTACT PERSON

This is the person we'll contact for any questions about this EFT.

Contact Person Name	Contact Person Title
Contact Person Phone	Contact Person E-mail

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.

VI. SIGNATURE

Authorized/Delegated Official Name (<i>Print</i>)	Authorized/Delegated Official Phone
Authorized/Delegated Official E-mail	
Authorized/Delegated Official Signature (<i>Note: Must be signed and dated to process.</i>)	Date

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.**