

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

PART I: REASON FOR SUBMISSION

Reason for Submission:

- New EFT Authorization
- Revision to Current Authorization
(e.g. account or bank changes)
- Check here if EFT payment is being made to the Home Office of Chain
(Attach letter Authorizing EFT payment to Chain Home Office)

Since your last EFT authorization agreement submission, have you had a:

- Change of Practice Location Address, and/or
- Chain Home Office Organization?
- If you checked either a change of ownership or change of practice location above, 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 ET authorization agreement submission.

PART II: PROVIDER OR SUPPLIER INFORMATION

Provider/Supplier Legal Business Name

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

Account Holder's Street Address

Account Holder's City	Account Holder's State	Account Holder's Zip Code
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Tax Identification Number: (designate SSN or EIN)

Medicare Identification Number (if issued)

National Provider Identifier (NPI)

PART III: FINANCIAL INSTITUTION INFORMATION

Financial Institution Name

Financial Institution Telephone Number	Financial Institution Contact Person
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Financial Institution Routing Transit Number (nine digit)

Depositor Account Number	Type of Account (check one)
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account

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.

PART IV: CONTACT PERSON

Contact Person's Name	Contact Person's Title
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Contact Person's Telephone Number	Contact Person's E-mail Address
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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 credit 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 fee-for-service contractor. 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 or 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 or 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

Authorized/Delegated Official Name (Print)	Authorized/Delegated Official Telephone Number
Authorized/Delegated Official Title	Authorized/Delegated Official E-mail Address
Authorized/Delegated Official Signature (Note: Must be original signature in black or blue ink.)	

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 60 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.

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 authorization or change to your 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.

PART II: PROVIDER OR SUPPLIER INFORMATION

- Line 1:** Enter the provider's/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 exclusively bear the name of the physician or individual practitioner, or the legal business name of the person or entity enrolled with Medicare.
- Line 2:** Enter the chain organization's name or the home office legal business name if different from the chain organization name.
- Line 3:** Enter the account holder's street address.
- Line 4:** Enter the account holder's city, state, and zip code.
- Line 5:** Enter the tax identification number as reported to the IRS. If the business is a corporation, provide the Federal employer identification number, otherwise provide your Social Security Number.
- Line 6:** If issued, enter the Medicare identification number assigned by a Medicare fee-for-service contractor. If you are not enrolled in Medicare, leave this field blank.
- Line 7:** Enter the 10 digit NPI number. The NPI is required to process this form.

PART III: FINANCIAL INSTITUTION INFORMATION

- Line 8:** 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.
- Line 9:** Enter the bank or financial institutional telephone number and contact person's name.
- Line 10:** Enter the bank or financial institutional nine-digit routing number, including applicable leading zeros.
- Line 11:** Enter the depositor's account number, including applicable leading zeros. Select the account type.

If you do not submit this information, your EFT authorization agreement will be returned without further processing.

PART IV: CONTACT PERSON

- Line 12:** Enter the name and title of a contact person who can answer questions about the information submitted on this CMS -588 form.
- Line 13:** Enter the contact person's telephone number. Enter the contact person's e-mail address.

PART V: AUTHORIZATION

- Line 14:** 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 Provider or Supplier. The Provider or Supplier 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 Provider or Supplier 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 this form with the original signature in black or blue ink (no facsimile signatures can be accepted) 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 fee-for-service contractor, go to: www.cms.hhs.gov/MedicareProviderSupEnroll.