INSTRUCTIONS FOR COMPLETING THE EFT AUTHORIZATION AGREEMENT

All EFT requests are subject to a 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'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 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.** Physicians and individual practitioners who have granted a Medicare-enrolled provider or supplier the right to receive payments for all of their services, is not required to complete this form. The account holder information should be of the person or entity receiving the reassigned benefits (e.g., Medicare Identification Number, Authorized/Delegated Official signature).
- Enter the Chain Home Office (CHO) legal business name. A CHO is an entity that provides centralized management and administrative services to the providers or suppliers under common ownership and common control, such as centralized accounting, purchasing, personnel services, management direction and control, and other similar services.
  NOTE: Providers/suppliers must report the legal business name provided on the IRS CP-575 form.
- Enter the account holder's street address.
  NOTE: Do Not Include PO Boxes.
- 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.
- A provider/supplier may only have one EFT account per enrollment.
- 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

- **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: Supporting bank documents must be in the provider's/supplier's/entity's legal business name only.
- Enter your Financial Institution's name (this is the name of the bank or qualifying depository that will receive the funds).
  NOTE: The Financial Institution's name must be the Legal Business Name on the account, electronic routing transit number and type.
  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.
  NOTE: Do Not Include PO Boxes.
- 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's/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's/supplier's/entity's legal business name only.

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.

Upload this form to PECOS or mail 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: **CMS.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/**.

Form Approved
OMB No. 0938-0626
Expires XX/20XX

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

PART I: REASON FOR SUBMISSION

Reason for Submission:

☐ New EFT Enrollment
☐ Individual ☐ Group

☐ Change to Current EFT Enrollment
(e.g. account or bank changes)

☐ Check here if EFT payment is being made to the Chain Home Office
(Attach letter Authorizing EFT payment to Chain Home Office)

PART II: ACCOUNT HOLDER INFORMATION

Provider/Supplier Legal Business Name *(If individual, please provide first name, middle initial, last name, and suffix)*

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

Account Holder's Street Address (Do Not Include PO Boxes.)

Account Holder's City	Account Holder's State	Account Holder's Zip Code

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)*	Medicare Identification Number *(if issued)*

PART III: FINANCIAL INSTITUTION INFORMATION

Financial Institution's Name

Financial Institution's Street Address (Do Not Include PO Boxes.)

Financial Institution's City/Town	Financial Institution's State/Province	Financial Institution's Zip Postal Code
Financial Institution's Telephone Number *(optional)*	Financial Institution's Contact Person *(optional)*	

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 *(check one)*
	☐ Checking Account ☐ Savings Account

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
Contact Person's Telephone Number	Contact Person's E-mail Address

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

Authorized/Delegated Official Name *(Print)*	Authorized/Delegated Official Telephone Number

Authorized/Delegated Official E-mail Address *(optional)*

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