Form Approved
OMB No. 0938-0626

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)

Chain Home Office: Organization
- ❑ Check here if EFT payment is being made to the Home Office of Chain (Attach letter Authorizing EFT payment to Chain Home Office)

PART II – PROVIDER OR SUPPLIER INFORMATION

Name _____

Provider/Supplier Legal Business Name _____

_____

Chain Organization Name _____

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

_____

Tax Identification Number: (Designate SSN ❑ or EIN ❑) ___ ___ ___ ___ ___ ___ ___ ___ ___

Medicare Identification Number *(if issued)* _____

National Provider Identifier (NPI) _____

PART III – DEPOSITORY INFORMATION (Financial Institution)

Depository Name _____

Street Address _____

City _____ State _____ Zip Code _____

Depository Telephone Number _____

Depository Contact Person _____

Depository Routing Transit Number (nine digit) ___ ___ ___ ___ ___ ___ ___ ___ ___

Depositor Account Number _____

Type of Account (check one) ❑ Checking Account ❑ Savings Account

Please include a voided check or deposit slip or confirmation of account information on bank letterhead. When submitting the documentation, it should contain the name on the account, electronic routing transit number, account number and type, and the bank officer's name signature. This information will be used to verify your account number.

PART IV – CONTACT PERSON

First Name	Middle Initial	Last Name

Telephone Number	Fax Number *(if applicable)*

Address Line 1 *(Street Name and Number)*

Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

E-mail Address

PART V – AUTHORIZATION

I hereby authorize the Centers for Medicare & Medicaid Services fee-for-service contractor, _____ _____, hereinafter called the CONTRACTOR, 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, hereinafter called the DEPOSITORY, to credit and/or debit the same to such account.

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 DEPOSITORY 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 the CONTRACTOR has received written notification from me of its termination in such time and such manner as to afford the CONTRACTOR and the DEPOSITORY a reasonable opportunity to act on it. The CONTACTOR will continue to send the direct deposit to the DEPOSITORY indicated above until notified by me that I wish to change the DEPOSITORY receiving the direct deposit. If my DEPOSITORY information changes, I agree to submit to the CONTRACTOR an updated EFT Authorization Agreement.

Signature Line

Authorized/Delegated Official Name (Print) _____

Authorized/Delegated Official Title _____

Authorized/Delegated Official Signature _____ 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.

Under 31 U.S.C. 3332(f)(1), all Federal payments, including Medicare payments to providers and suppliers, shall be made by 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.

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 – IDENTIFICATION DATA

Line 1 – Enter the name of the physician or individual practitioner, or the legal business name of the provider/supplier as reported to the Internal Revenue Service (IRS). The account to which 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 provider's/supplier's legal business name. 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 3 – Enter the chain organization's name.

Line 4 – Enter the home office legal business name if different from the chain organization name.

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 – DEPOSITORY INFORMATION (Financial Institution)

Line 8 – Enter your depository name (this is the name of the bank or qualifying financial institution that will receive the funds).

Line 9 – Enter the depository's street address.

Line 10 – Enter the depository's city, state and ZIP code.

Line 11 – Enter the bank or financial institutional telephone number.

Line 12 – Enter the depository's contact person.

Line 13 – Enter the bank or financial institutional nine-digit routing number.

Line 14 – Enter the depositor's account number and 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

Enter the information for the contact person responsible for this EFT authorization agreement.

PART V – AUTHORIZATION

Enter the name of the CMS fee-for-service contractor in Part V who has authority to initiate credit entries.

Line 24 – 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 depository 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 the Medicare contractor regarding any changes in the account in sufficient time to allow the contractor and the depository 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.

Mail this form with the original signature (no facsimile signatures can be accepted) to the Medicare contractor that services your geographical area. To locate the mailing address for your fee-for-service contractor, go to: *www.cms.hhs.gov/MedicareProviderSupEnroll.*