DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved OMB
No. 0938-0626
Expires: 01/2020

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)

☐ Cancel EFT Enrollment

☐ 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)

Please list the following:
Profit
MDPCP
Application Number

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

☐ Change of Ownership, and/or

☐ Change of Practice Location?

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 EFT authorization agreement submission.

PART II: ACCOUNT HOLDER INFORMATION

Provider/Supplier/Indirect Payment Procedure (IPP) Biller Legal Business Name
Practice Name (e.g. Smith Practice)

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

Account Holder's Street Address
Practice Address (e.g. 123 Main Street)

Account Holder's City	Account Holder's State	Account Holder's Zip Code
Baltimore	MD	21202

Tax Identification Number (TIN)
1 2 3 4 5 6 7 8 9 1 2 3

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

Medicare Identification Number (if issued)
X

Health Plan Identifier (HPID) or Other Entity Identifier (OEID) (IPP Entities Only)
X

National Provider Identifier (NPI)
X

National Provider Identifier (NPI)

National Provider Identifier (NPI)

PART III: FINANCIAL INSTITUTION INFORMATION

Financial Institution's Name
TD Bank

Financial Institution's Street Address
123 Park Avenue

Financial Institution's City/Town	Financial Institution's State/Province	Financial Institution's Zip Postal Code
Baltimore	MD	21203

Financial Institution's Telephone Number	Financial Institution's Contact Person (optional)
(123) 123-0000	

Financial Institution Routing Number (must be 9 digits)
9 8 7 6 5 4 3 2 1

Provider's/Supplier's/IPP Entity's Account Number with Financial Institution (include all zeroes)
0 0 0 0 0 0 0 1 2 3 4 5 6 7 8 9 1

Type of Account (check one)
- ● Checking Account
- ○ 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. **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
John Smith	Practice Coordinator
Contact Person's Telephone Number	**Contact Person's E-mail Address**
(123) 123-4567	john.smith@gmail.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 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 or IPP entity, the said Provider/Supplier or IPP entity 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 or IPP entity 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
John Smith	(123) 123-4567
Authorized/Delegated Official Title	**Authorized/Delegated Official E-mail Address**
Practice Coordinator	john.smith@gmail.com
Authorized/Delegated Official Signature *(Note: Must be original signature in black or blue ink.)*	**Date**
John Smith	10/04/2018

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.

DO NOT MAIL THIS FORM TO THIS ADDRESS.
MAILING YOUR APPLICATION TO THIS ADDRESS WILL SIGNIFICANTLY DELAY PROCESSING.