Form Approved
OMB No. 0938-0626

AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER (EFT)

Reason for Submission:
- ❑ New EFT Authorization
- ❑ Revision to Current Authorization *(i.e. account or bank changes)*
- ❑ EFT Termination Request

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

Physician/Provider/Supplier Information

Physician's Name _____

Provider/Supplier Legal Business Name _____

_____

Chain Organization Name _____

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

_____

Tax ID Number: *(Designate SSN* ❑ *or EIN* ❑*)* ___ ___ ___ ___ ___ ___ ___ ___ ___

Doing Business As Name _____

Medicare Identification Number (*OSCAR, UPIN, or NSC only)* _____

Depository Information (Financial Institution)

Depository Name _____

Account Holder's 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, preprinted deposit slip, or confirmation of account information on bank letterhead with this agreement for verification of your account number.

Authorization

I hereby authorize the Medicare contractor, _____, hereinafter called the COMPANY, 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 Physician/Provider/Supplier certifies that he/she has sole control of the account referenced above, and certifies that all arrangements between the DEPOSITORY and the said Physician/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 the COMPANY has received written notification from me of its termination in such time and such manner as to afford the COMPANY and the DEPOSITORY a reasonable opportunity to act on it. The COMPANY 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 COMPANY 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.

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.

Furnishing information is voluntary, but without it we will not be able to process your electronic funds transfer.

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.

Instructions for Completing the Authorization Agreement for EFT

The following instructions will guide you through the EFT Authorization process. If you are submitting multiple requests, a separate Authorization Agreement must be completed for each provider identification number (OSCAR, UPIN, or NSC). 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. In the meantime, all payments will be mailed via hard copy checks directly to the "Pay To" address that the Medicare contractor currently has on file. Please contact the Provider Enrollment Unit to verify the "Pay To" address. This agreement must be completely filled out. Omission of any information will delay the processing of your request. If you have any questions, please contact your Medicare contractor. For a list of contractors see www.cms.hhs.gov/providers/enrollment/contacts/.

Please indicate your reason for completing this form: New EFT authorization; Change to your account information; or Termination of your EFT authorization.

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.

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 EFT payments are 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.

For EFT payments to the Home Office of a Chain Organization, the depository account must be established in the legal business name of the Home Office, and must match the Home Office name provided above on this form, as well as the Home Office name provided in the appropriate sections of the relevant Form CMS-855 (Provider/Supplier Enrollment Application).

Enter your Tax Identification Number as reported to the IRS. If the business is a corporation, provide the Federal Employer Identification Number (EIN), otherwise provide your SSN.

Enter your Medicare Identification Number. If you are a Part A Provider, or certified Supplier this will be your 6-digit OSCAR number. If you are enrolled as an individual practitioner or a group practice this will be the 6-position alphanumeric UPIN. If you are enrolled as a supplier of durable medical equipment, this will be the 10-digit National Supplier Clearinghouse number.

Enter your depository name (this is the name of the bank or qualifying financial institution that will receive the funds), address, name of a contact person, and contact person's telephone number.

Enter your electronic Routing Transit Number, Account Number, and the type of account in which deposits will be made (Checking or Saving). Attach a voided check, preprinted deposit slip, or confirmation of account information on bank letterhead for verification of your account number. The documentation on bank letterhead should confirm the name on the account, electronic routing transit number, account number and type, and the bank officer's name and signature.

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

Read the Authorization carefully. By your signature on this form you are certifying:

1. That the account is drawn in the Name of the Physician or Individual Practitioner, or the Legal Business Name of the Provider/Supplier;
2. The Physician/Provider/Supplier has sole control of the account to which EFT deposits are made in accordance with all applicable Medicare regulations and instructions;
3. That all arrangements between the depository and the said Physician/Provider/Supplier are in accordance with all applicable Medicare regulations and instructions;
4. The effective date of the EFT authorization; and
5. That you will 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 Form CMS-855 which the Medicare contractor has on file.

Mail this form with the original signature (no Fax signatures can be accepted) to the Medicare Contractor that services your geographical area. For a listing of contractors, see www.cms.hhs.gov/providers/enrollment/contacts/.