CMS Federal Program
Contractor's
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Electronic Data Interchange (EDI) Enrollment Form

This Agreement notifies _(fill in contractor name here)_ of the provider's consent to participate in Electronic Data Interchange (EDI). EDI may include claims and claims attachments, remittances, eligibility/benefits, claim status, and any other electronic information for Centers for Medicare and Medicaid Services (CMS) federal program data (including but not limited to Title XVIII of the Social Security Act (Medicare), and/or Section 1011 of the Medicare Modernization Act) covered under Health Insurance Portability and Accountability Act (HIPAA) Transactions and Code Sets or Section 1011 of the Medicare Modernization Act (MMA) legislation.

A. The provider agrees:

1. That it will establish and maintain procedures and controls so that information concerning Medicare and/or Section 1011 beneficiaries, or any information obtained from CMS or its contractors, shall not be used by agents, officers, or employees of a business associate except as provided by the contractor (in accordance with §1106(a) of the Social Security Act (the Act));
2. That it will use sufficient security procedures (including compliance with all provisions of the HIPAA security regulations) to ensure that all electronic transmissions are authorized and protect all beneficiary-specific data from improper access;
3. That it will notify the contractor or CMS within two business days if any transmitted data are received in an unintelligible or garbled form.
4. The provider agrees to the following provisions for submitting and retrieving/receiving Medicare and/or Section 1011 information electronically to/from CMS or CMS contractors:

    a) That it will be responsible for all Medicare and/or Section 1011 transactions submitted to CMS by the provider, its employees, or its business associates;

    b) That it will not disclose any information concerning a Medicare and/or Section 1011 beneficiary to any other person or organization, except CMS and/or its contractors, without the express written permission of the Medicare/Section 1011 beneficiary or his/her parent or legal guardian, or where required for the care and treatment of a beneficiary who is unable to provide written consent, or to bill insurance primary or supplementary to Medicare and/or Section 1011, or as required by State or Federal law;

    c) That it will submit claims only on behalf of those Medicare and/or Section 1011 beneficiaries who have given their written permission to do so, and to certify that required beneficiary signatures, or legally authorized signatures on behalf of beneficiaries, are on file;

    d) That it will submit/request electronic transactions on only those beneficiaries with whom the provider has a professional relationship;

    e) That the CMS-assigned unique identifier number (submitter identifier) constitutes the provider's legal electronic signature and when used for claims submission, it constitutes an assurance by the provider that services were performed as billed;

    f) That it will ensure that every electronic claim can be readily associated and identified with an original source document. Each source document must reflect the following information (except if not required for Section 1011):

- Beneficiary's name;
- Beneficiary's health insurance claim number;
- Date(s) of service;
- Diagnosis/nature of illness; and
- Procedure/service performed;

5. That the Secretary of Health and Human Services or his/her designee and/or the CMS contractor has the right to audit and confirm information submitted by the provider and shall have access to all original source documents and medical records related to the provider's submissions, including the beneficiary's signature. All incorrect payments that are discovered as a result of such an audit shall be adjusted according to the applicable provisions of the Social Security Act, Federal regulations, and CMS guidelines;
6. That it will ensure that all claims for Medicare or Section 1011 primary payment have been developed for other insurance involvement and that Medicare/Section 1011 is indeed the primary payer;
7. That it will submit claims that are accurate, complete, and truthful;
8. That it will retain all original source documentation and medical records pertaining to any such particular Medicare claim for a period of at least six years, three months after the bill is paid, or, for Section 1011 beneficiaries, in accordance with the Section 1011 Final Policy Notice;
9. That it will research and correct claim discrepancies;
10. That it will affix the CMS-assigned unique identifier number (submitter identifier) of the provider on each claim electronically transmitted to the CMS contractor;
11. That it will acknowledge that all claims will be paid from Federal funds, that the submission of such claims is a claim for payment under the Medicare or Section 1011 program, and that anyone who misrepresents or falsifies or causes to be misrepresented or falsified any record or other information relating to that claim that is required pursuant to this Agreement may, upon conviction, be subject to a fine and/or imprisonment under applicable Federal law;
12. That if it chooses to participate in electronic remittance transactions it will notify the CMS contractor of any changes in third-party services that it has authorized to access this information on their behalf via the EDI Enrollment form;
13. That if it chooses to use a Network Service vendor for eligibility verification transactions it will notify the CMS contractor of any changes in third-party service arrangements via the EDI Enrollment form;

B. The Centers for Medicare & Medicaid Services (CMS) agrees to:

1. Transmit to the provider an acknowledgment of claim receipt;
2. Affix the CMS contractor number, as its electronic signature, on each remittance advice sent to the provider;
3. Ensure that payments to providers are timely in accordance with CMS' policies;
4. Ensure that no CMS contractor may require the provider to purchase any or all electronic services from the CMS contractor or from any subsidiary of the CMS contractor or from any company for which the CMS contractor has an interest. The carrier or FI will make alternative means available to any electronic biller to obtain such services;
5. Ensure that all Medicare electronic billers have equal access to any services that CMS requires Medicare contractors to make available to providers or their billing services, regardless of the electronic billing technique or service they choose. Equal access will be granted to any services the CMS contractor sells directly, or indirectly, or by arrangement;
6. Notify the provider within two business days if any transmitted data are received in an unintelligible or garbled form.

NOTICE: *Federal law shall govern both the interpretation of this document and the appropriate jurisdiction and venue for appealing any final decision made by CMS under this document. This document shall become effective when signed*

by the provider. The responsibilities and obligations contained in this document will remain in effect as long as Medicare/Section 1011 claims or any other EDI transactions are submitted to CMS or the CMS contractor. Either party may terminate this arrangement by giving the other party thirty (30) days written notice of its intent to terminate. In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.

C. Signature

I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

Provider's Name
Title
Address
City/State/Zip
Medicare provider number:
Submitter number (if applicable):
Signed By:
Printed Name:
Title
Date

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)

☐ 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 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: 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

Tax Identification Number: (designate ☐ SSN or ☐ EIN)

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Medicare Identification Number (if issued)

National Provider Identifier (NPI)

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PART III: FINANCIAL INSTITUTION INFORMATION

Financial Institution Name

Financial Institution City/Town	Financial Institution State
Financial Institution Telephone Number	Financial Institution Contact Person

Financial Institution Routing Transit Number (nine digit)

☐☐☐☐☐☐☐☐☐

Depositor Account Number	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.

PART IV: CONTACT PERSON

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 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.)*	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.

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 city or town where your financial institution is located. Enter the state where your financial institution is located.

Line 10: Enter the bank or financial institutional telephone number and contact person's name.

Line 11: Enter the bank or financial institutional nine-digit routing number, including applicable leading zeros.

Line 12: 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 13: Enter the name and title of a contact person who can answer questions about the information submitted on this CMS-588 form.

Line 14: Enter the contact person's telephone number. Enter the contact person's e-mail address.

PART V: AUTHORIZATION

Line 15: 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.gov/MedicareProviderSupEnroll.*