DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Thank you for your interest in Medicare Easy Pay. By completing and returning the Authorization Agreement for Preauthorized Payments form (SF-5510), you're authorizing the Centers for Medicare & Medicaid Services (CMS), the Federal agency that runs Medicare, to deduct your monthly Medicare premium from your bank account. This notice tells you what happens once you complete and return the form.

What information do I need to put on the form?
The form asks for basic information about you and your bank (also called a financial institution). **Have your red, white, and blue Medicare card and a blank check from your bank account with you when you fill out the form.**

Here are a few tips to help you:

When the form asks for	Do this
Individual/Organization Name	Enter your name the way it looks on your Medicare card.
Your Agency Account Identification Number	Enter your Medicare number from your Medicare card.
Type of Payment	Enter "Medicare Premiums" (this field is prefilled on the form).
Nine-Digit Routing Number	Enter the number from the bottom left corner of your check.
Account Title	Enter the name of the account holder or the individual who has power of attorney.
Account Number	Enter the checking or savings account number (don't use spaces or symbols).

If you're using a checking account to pay your premiums, attach a voided check for your checking account.

Where do I send the completed form?

Centers for Medicare & Medicaid Services
Medicare Premium Collection Center
P.O. Box 979098
St. Louis, MO 63197-9000

What happens once I return this form?

We'll process your form once we get it. Sometimes this can take 6 to 8 weeks. If we can't process your form, we'll return the form to you with a letter explaining why.

CMS Product No. 11636
January 2013

Two things will happen each month after your request is processed:

1. You'll get a Notice of Medicare Premium Payment Due stating, "This is not a bill" to let you know that the premium will be deducted from your bank account.

2. We'll deduct your premium from your bank account (usually on the 20th of the month). It will appear on your bank statement as an "Automated Clearing House (ACH)" transaction.

We'll only try to deduct your premium once each month. If your bank rejects or returns your premium deduction, we'll send you a letter with instructions on how to make a direct payment to Medicare.

Do I need to do anything when my premium amounts change?
No, we will automatically deduct the new premium amount from your bank account.

What if I want to change bank accounts or stop Medicare Easy Pay?
Complete another Authorization Agreement for Preauthorized Payments form (SF- 5510), and indicate the type of change you want to make. Mail the completed form to the address above. You can get a new form at **www.medicare.gov** or by calling 1-800-MEDICARE.

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January 2013

AUTHORIZATION AGREEMENT FOR PREAUTHORIZED PAYMENTS

OMB No.: **1510-0059**
Expires: 05/31/2017

Centers for Medicare & Medicaid Services

(AGENCY NAME)

Paperwork Reduction Act/Privacy Act Statement

The information requested on this form is required under various provisions of title 15 USC Chapter 41, 12 CFR 205, and 31 CFR 202 and 206, for the purpose of authorizing the Department of Treasury to designate financial institutions to electronically collect payments from your account. The information will be used to match the records of the government agency with those of the financial institution to direct your payments to the point you authorize. No electronic collection from your account may be transacted unless a signed authorization form is received. Furnishing this information is voluntary, however, failure to furnish this information may delay or prevent the electronic collection of a payment through the Automated Clearing House. You are not required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this collection of information is 1510-0059. We estimate that it will take approximately 15 minutes to complete this form.

CHECK ONE: ☐ START ☐ CHANGE ☐ STOP

INDIVIDUAL/COMPANY INFORMATION

INDIVIDUAL/ORGANIZATION NAME *(PLEASE PRINT)*

STREET ADDRESS

CITY/STATE: | ZIP CODE:

AREA CODE: | TELEPHONE NUMBER:

YOUR AGENCY ACCOUNT IDENTIFICATION NUMBER: | TYPE OF PAYMENT: Medicare Premiums

I hereby authorize the initiation of a deduction from my account and the financial institution named below to debit such account. I understand I will be notified if the debit amount needs to be adjusted, either to be increased or decreased. I also understand that I have the right to stop automatic payment by notifying my financial institution in writing three days prior to the time my account is charged.

SIGNATURE: _____ DATE: _____

FINANCIAL INSTITUTION INFORMATION

FINANCIAL INSTITUTION NAME:

STREET ADDRESS

CITY/STATE: | ZIP CODE:

NINE-DIGIT ROUTING TRANSIT NUMBER: ▶ | | | | | | | | | |

ACCOUNT TITLE

ACCOUNT NUMBER

☐ **CHECKING**
☐ **SAVINGS**

SIGNATURE AND TITLE OF REPRESENTATIVE | AREA CODE/TELEPHONE NUMBER | DATE