Please fill out form and fax to Provider Relations at 915-225-6762

Questions/Concerns call 915-532-3778 x1507

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH CREDITS)

Provider/Group Name: _____

NPI Number: _____

Tax ID Number: _____

I (we) hereby authorize:

El Paso Health to initiate credit entries to the account at the depository financial institution named below, hereafter-called DEPOSITORY, and to credit the same to such account. I (we) acknowledge that the origination of ACH transaction to my (our) account must comply with the provisions of the U.S. law.

Name of Depository Account: _____

Bank / Financial Institution Name: _____

Account Type (please check one):

☐ Checking Account

☐ Savings Account

City: _____

State: _____ Zip code: _____

Account number: _____

Routing number: _____

This authorization is to remain in full force and effect until El Paso Health has received written notification from me (or either of us) of its termination in such time and in such manner as to afford El Paso Health and DEPOSITORY a reasonable opportunity to act on it

Name(s): _____

Title: _____

Date: _____

Signature: _____

NOTE: CREDIT AUTHORIZATION MUST PROVIDE THAT THE RECEIVER MAY REVOKE THE AUTHORIZATION ONLY BY NOTIFYING THE ORIGINATOR IN THE MANNER SPECIFIED IN THE AUTHORIZATION.

ATTACH A VOIDED CHECK