ELECTRONIC PAYMENT/FUNDING REQUEST FORM

This form must be fully completed and accompanied by the following documents:

1) Letter from your financial institution confirming the account information listed below or a copy of a voided check.
2) A current W-9 for your company or organization.

Please allow 2 weeks for set up and processing.

Authorization Agreement

I hereby authorize **Providence Health Assurance** (PHA) and/or **Providence Health Plan** (PHP) to initiate electronic payment/funding to the identified account at the financial institution named below.

Further, I agree not to hold **PHA** and/or **PHP** responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until **PHA** and/or **PHP** receives a written notice of cancellation from me or my financial institution, or until I submit a new ACH enrollment form to the Accounting Department at **PHA** and/or **PHP**.

United States Checking Account Information	
Bank Name:	
Bank Address:	
Bank City, State, Zip:	
Bank Routing #:	
Account #:	
Account Type (check one):	☐Checking ☐Savings

Remittance Contact Information	
Payee Name:	
Contact Person:	
Email address:	
Contact Phone/Ext.:	
Contact FAX Number:	

Signature – Please print and sign. Must be signed by a corporate officer. By signing this document, I certify I am duly authorized and have legal authority to sign this legally binding authorization agreement, and the account information provided is accurate.

Authorized Signature:
Print Name, Title and Date:

Comments, if any.

Revised 02/25/2020