# Alliance Health

## AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER (EFT)

| **Initial Request** | **Change Request** | **Cancel Request** |
|---|---|---|

| **VENDOR INFORMATION** | | | |
|---|---|---|---|
| 1. VENDOR LEGAL BUSINESS NAME (must match name on financial institution account and name registered with Alliance Health, if applicable) | | | |
| 2. ACCOUNT HOLDER'S NAME | | | 3. CONTACT TELEPHONE NUMBER |
| 4. VENDOR ADDRESS | CITY | STATE | ZIP |
| 5. VENDOR COMPLETE FEDERAL TAX ID NUMBER (must match number registered with Alliance Health, if applicable) | | | |
| 6. EMAIL ADDRESS – for Electronic Remittance Forms to be Sent | | | |

| **FINANCIAL INSTITUTION INFORMATION** | | | |
|---|---|---|---|
| 1. FINANCIAL INSTITUTION ROUTING NUMBER | | 2. FINANCIAL INSTITUTION ACCOUNT NUMBER (include leading zeros) | |
| 3. TYPE OF ACCOUNT<br>CHECKING SAVINGS | | 4. FINANCIAL INSTITUTION TELEPHONE NUMBER | |
| 5. FINANCIAL INSTITUTION NAME | | | |
| 6. FINANCIAL INSTITUTION ADDRESS | CITY | STATE | ZIP |

This authorization is effective as of the signature date below and is to remain in full force and effect until Alliance Health has received written notification of its termination in such time and such manner as to afford Alliance Health and the financial institution a reasonable opportunity to act on it, or until Alliance Health deems it necessary to terminate this agreement. Under penalties of perjury, I hereby certify the checking OR savings account indicated on this form are under my direct control and access; therefore, I authorize Alliance Health to initiate, change, or cancel credit entries to the financial institution account as indicated above. If my financial institution information changes, I agree to submit to Alliance Health a revised Authorization Agreement for Electronic Funds Transfer form.

I hereby CANCEL my EFT authorization.

I understand that by signing this form, payments issued will be Federal and State funds, and that any falsification or concealment of a material fact may be prosecuted under Federal and State laws.

Print Name

Signature Date

**It is requested that you include a blank, void check or bank generated account verification form for account and routing number verification.**

**If neither of these documents are provided as requested, Alliance Health does not accept responsibility for the accuracy of the above typed/written account information submitted by the Provider/Vendor.**

**Please submit this form and a voided check or bank letter by using "Submit Electronically" button below or email to vendorsetup@alliancehealthplan.org**