St. Joseph Heritage Healthcare

ST. JOSEPH HERITAGE HEALTHCARE
OTHER DIRECT DEPOSIT PLAN
AUTHORIZATION AGREEMENT

EFFECTIVE DATE: _____

We authorize and request St. Joseph Heritage Healthcare ("SJHH") and the bank named below to initiate direct electronic deposits to our checking/savings account to pay us monies owed by SJHH for:

_____ Fee for Service Claims _____ Capitated Service

BUSINESS FINANCIAL INFORMATION:

Please fill in the following information:

Account Number _____ ABA# _____

Name of Financial Institution _____

Address of Financial Institution _____

City _____ State _____ Zip _____

Phone # (_____) _____ FAX# (_____) _____

This authorization will remain in full force and effect until we send written notification of its termination to SJHH.

Allow 20 business days for direct deposits to go into effect. If your account-number changes or you close your account you must notify St. Joseph Heritage Healthcare in writing immediately and a new form will be required. A live check will be issued until the new bank information can be verified.

Attention: Electronic Fund Transfers (EFT)
Fax form to 714-937-6220
Phone 714-937-6203

BUSINESS INFORMATION:

Business Name _____ TIN# _____

Address _____

City _____ State _____ Zip _____

E-mail Address: _____ FAX# (_____) _____

Phone Number: (_____) _____

Signature _____ Date _____

Title _____

FOR OFFICE USE ONLY:

NSS CAO Approval: _____ Finance Director Approval: _____

Dated Entered: _____ Initials: _____

Term Rec'd: _____ Entered: _____ Initials: _____