**ACH/Direct Deposit Authorization Form**

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| **1. Please Check One:**  |
|  [ ]  NEW ACH Information [ ]  CHANGE ACH Information [ ]  Existing ACH Payee (complete section 2&4 only) |

**\*Please type or write legibly\***

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| **2. Payee Information**  |
| **Name:**  |
| **Address:**  |
| **Contact Person:**  |
| **Remittance Advice Email Address: Telephone Number:**  |

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| **3. Financial Institution Information**  |
| **Bank Name:**  |
| **Bank Address:**  |
| **Bank Account Number:**  |
| **Nine-Digit Bank Routing Number:**  |
| **Type of Account:** [ ]  **Checking** [ ]  **Savings** **\*If you choose to provide a handwritten copy of the form, please include a copy of a voided check\*** |

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| **4. Approvals/Authorizations -** I certify that the information provided on this form is correct, and I hereby authorize iMPROve Health to initiate/change/cancel electronic deposit payments to the bank account designated above. I further authorize iMPROve Health to reverse any payment made to this account in error. |
| Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Important Information**  |
| Please fax or e-mail completed forms to:iMPROve HealthIDREAccounting@improve.healthFax Number: 248-305-5365 |