Vendor ACH/Direct Deposit Authorization Form

EBA

1. Please Check One:
☐ NEW Direct Deposit ☐ CHANGE Direct Deposit ☐ CANCEL Direct Deposit

2. Vendor/Payee Information
Name:
Address:
Contact Person's Name (if other than payee):
Telephone Number:
Email Address:

3. Financial Institution Information
Bank Name:
Bank Address:
Name on Bank Account:
Bank Account Number:
Nine-Digit Bank Routing/Transit Number (ABA):
Type of Account: ☐ **Checking** ☐ **Savings**

4. Approvals/Authorizations - I certify that the information provided on this form is correct, and I hereby authorize EBA to electronically deposit payments to the bank account designated above. It is my responsibility to notify EBA immediately if I believe there is a discrepancy between the amount deposited to my bank account and the amount of the invoice(s) paid. I understand that I must notify EBA in writing immediately of any changes in status or banking information. I understand that this authorization will remain in full force and effect until EBA has received written notification requesting a change or cancellation and has had reasonable opportunity to act on it, which should take no longer than seven (7) to ten (10) business days.

Print Name:_____ Signature:_____ Date:_____

Important Information

Please return completed form via email: **levi.lewis@empowercommunitycare.com Please send a copy of a voided check for verification**.

For Office of Accounting Only	Date Stamp - Received
AP Reviewed and Approved: Date:	