Direct Deposit Authorization Form

Exceptional Service and Savings

Complete Fields Below:

Name of Business (Please Print) ____

Tax ID ____________________ Work Phone: ______________ Email: ________________________

Contact Last Name: ___________________________ First Name: ____________________________

Address: ________________________________ City: _________________ State: ____ Zip: _______

Financial Institution: ____ Branch: _________________

Type of Account: Checking Savings Check Action: New Change Cancel

Routing Transit Number
(All nine boxes must be filled)

Account Number
(Include hyphens, but not spaces and special symbols)

ATTACH A COPY OF <u>VOIDED</u> CHECK HERE

(Do not attach deposit slips, as they do not supply the necessary information)

Joan Doe
Anywhere, USA

PAY TO THE ORDER OF ______________________ $ ______

______________________________________ DOLLARS

YOUR TOWN BANK
YOUR TOWN, AR 12345
FOR ____________________ **VOID**

⑆255500055⑆ 1234556789022⑈

This authority is to remain in full force and effective until Direct Pay Provider Network, hereinafter called Direct Pay, has received written notification of its termination in such time and manner as to afford Direct Pay a reasonable opportunity to act on it.

By signing this agreement, I (we) hereby authorize Direct Pay to initiate credit entries to the account(s) indicated above for the purpose of medical reimbursements and to initiate, if necessary, debit entries and adjustments for any credit entries made in error.

Authorized Signature ____ **Date** ______/______/______
mm/dd/yy

If the account requires dual signatures for authorization, please sign below to indicate agreement with the statement above.

Authorized Signature ____ **Date** ______/______/______
mm/dd/yy

Direct Pay Provider Network
P.O. Box 1926 Pelham, AL 35124
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www.dpaynetwork.com