Direct Deposit Authorization Form

Complete All Fields Below:

directPAY PROVIDER NETWORK

Exceptional Service and Savings

Tax ID _____

Name of Business (Please Print) _____

Contact Phone: _____ Contact Email: _____

Contact Last Name: _____ First Name: _____

Please make sure the contact above has access to the bank statement to verify payment has been received. We must have an email address and contact number for this person. We do not mail EOBs. This contact will be the individual who will obtain access to our portal to download EOBs as well as verifying payments.

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)

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

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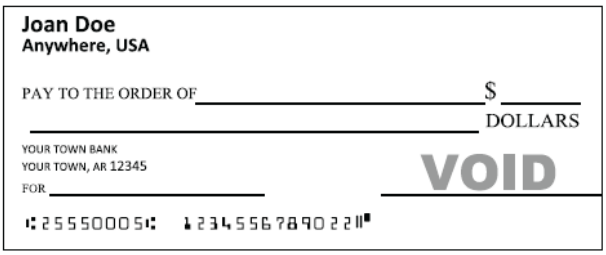
ATTACH A COPY OF VOIDED CHECK HERE

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



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
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