Alliance Behavioral Healthcare

AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER (EFT)

◯ **Initial Request** ◯ **Change Request** ◯ **Cancel Request**

PROVIDER INFORMATION			
1. PROVIDER LEGAL BUSINESS NAME (must match name on financial institution account and name registered with Alliance Behavioral Healthcare)			
2. ACCOUNT HOLDER'S NAME			3. CONTACT TELEPHONE NUMBER
4. PROVIDER ADDRESS	CITY	STATE	ZIP
5. PROVIDER COMPLETE FEDERAL TAX ID NUMBER (must match number registered with Alliance Behavioral Healthcare)			
6. EMAIL ADDRESS – for Electronic Remittance Forms to be Sent			

FINANCIAL INSTITUTION INFORMATION			
1. FINANCIAL INSTITUTION ROUTING NUMBER		2. FINANCIAL INSTITUTION ACCOUNT NUMBER (include leading zeros)	
3. TYPE OF ACCOUNT ◯ CHECKING ◯ SAVINGS		4. FINANCIAL INSTITUTION TELEPHONE NUMBER	
5. FINANCIAL INSTITUTION NAME			
6. FINANCIAL INSTITUTION ADDRESS	CITY	STATE	ZIP

☐ This authorization is effective as of the signature date below and is to remain in full force and effect until Alliance Behavioral Healthcare has received written notification of its termination in such time and such manner as to afford Alliance Behavioral Healthcare and the financial institution a reasonable opportunity to act on it, or until Alliance Behavioral Healthcare deems it necessary to terminate this agreement. Under penalties of perjury, I hereby certify the checking OR savings account indicated on this form are under my direct control and access; therefore, I authorize Alliance Behavioral Healthcare to initiate, change, or cancel credit entries to the financial institution account as indicated above. If my financial institution information changes, I agree to submit to Alliance Behavioral Healthcare a revised Authorization Agreement for Electronic Funds Transfer form.

☐ I hereby CANCEL my EFT authorization.

I understand that by signing this form, payments issued will be Federal and State funds, and that any falsification or concealment of a material fact may be prosecuted under Federal and State laws.

_____
Print Name

_____
Signature Date

It is requested that you include a blank, void check or bank generated account verification form for account and routing number verification. If neither of these documents are provided as requested, Alliance Behavioral Healthcare does not accept responsibility for the accuracy of the above typed/ written account information submitted by the Provider/Vendor. Please attach a voided check or an original bank letter and mail to:

Alliance Behavioral Healthcare
Attention: Finance
4600 Emperor Boulevard
Suite 200
Durham, NC 27703