

The Health Plan Direct Deposit Authorization Form



St. Clairsville Office
 52160 National Road East
 St. Clairsville, OH 43950-9365
 PH: 1.800.624.6961
 Hearing Impaired: 1.800.622.3925
 FAX: 740.695.5297
www.healthplan.org

HomeTown Office
 100 Lillian Gish Boulevard
 P.O. Box 4816
 Massillon, OH 44648-4816
 PH: 1.877.236.2289
 Hearing Impaired: 1.877.236.2291
 FAX: 330.837.6869
www.healthplan.org

(Please Print)

Direct Deposit is available to all participating Health Plan provider. Funds can be electronically credited to any commercial account if the Financial Institution is a member of an Automated Clearinghouse(ACH). You can confirm this by contacting your Bank.

This form must be entirely completed and a **Voided Check** for the Account or a Micr Encoded Specification Sheet (can be obtained from your bank) must be included with this authorization form.

Provider Name (Legal Entity):		Tax Identification Number:	
Provider Billing Street Address:			
City:		State:	ZIP Code:
Contact Name:		Telephone: ()	
Please Check One:	<input type="checkbox"/> Cancellation	<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Change

BANK ACCOUNT INFORMATION

Bank Routing Number:		Bank Account Number:	
Bank Account Name:			
LISTED NUMBER REFERS TO: (Please Check One)			
<input type="checkbox"/> Business Checking Account	<input type="checkbox"/> Business Savings Account	<input type="checkbox"/> Other	
Bank Name:			
Bank Street Address:			
City:		State:	ZIP Code:

Authorization is hereby granted to The Health Plan to credit said account at the financial institution named above for the purpose of transferring The Health Plan payments. This authorization is to remain in effect until notification is given to The Health Plan in writing (at least ten (10) days notice) on The Health Plan Direct Deposit Authorization Form advising of a change, allowing reasonable time to implement such changes.

Authorization Signature:	Printed Name:	
	Title:	Date: