

## ACH Authorization Form

I (we) hereby authorize Vivant Health (The Company) to initiate entries to my (our) checking/savings accounts at the financial institution listed below (The Financial Institution), and if necessary, initiate adjustments for any transactions credited/debited in error. This authority will remain in effect until The Company is notified by me (us) in writing to cancel it in such time as to afford The Company and The Financial Institution a reasonable opportunity to act on it.

**(You must mail the original ACH form with a voided check to the address above.)**

Name of Financial Institution: \_\_\_\_\_

Address of Financial Institution – branch, city, state, and ZIP: \_\_\_\_\_

Provider tax ID#: \_\_\_\_\_

Name on check – PLEASE PRINT: \_\_\_\_\_

Address on check – PLEASE PRINT: \_\_\_\_\_

Check signer signature: \_\_\_\_\_ Date: \_\_\_\_\_

Financial Institution routing number: \_\_\_\_\_

Checking/savings account number: \_\_\_\_\_

These numbers are as follows:

Routing number: _____	Account number: _____
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Email address to send ACH transfer notifications: \_\_\_\_\_

Contact person name: \_\_\_\_\_ Contact person phone: \_\_\_\_\_

Contact fax number: \_\_\_\_\_

Fax the ACH form to:

Michelle Long  
Fax: **(916) 400-3982**