OhioHealth

ACH Payment Enrollment Form

OhioHealth offers the option of receiving payments via ACH to our vendors. Payments will be electronically deposited into your company's designated bank account through ACH (Automated Clearing House). ACH payment remittance advice will be delivered via email.

Vendor Name:_____ _____

Effective Date: _____ Date of Request: _____

Venfor Number: _____ Tax ID Number: _____

☐ Add ☐ Change to Banking or Contact Information

Vendor Contact Information

Main Contact

Name of Contact: _____

Phone Number: _____

Email: _____

Back Up

Name of Contact: _____

Phone Number: _____

Email: _____

Bank Information - ACH

Bank Name: _____

Routing Number: _____

Account Number: _____

Remittance Advice Email _____

☐ Remove

Removing from ACH will move payments to crecit card

Authorization:

I certify that the above information is true and correct, and that as a represntative from the above named company, I herby authrize OhioHealth to electronically depoist payments to the designated bank account. This authoriy remains in force until OhioHealth recieve a signed form requesting a change or cancellation.

Printed Name: _____ Title: _____

Signature: _____ Date: _____

PLEASE SEND THE FOLLOWING WITH YOUR ACH ENROLLMENT FORM

1. a current, completed signed W-9.
2. a voided check from your account OR a letter from your bank to confirm your bank account and routing number.

THIS INFORMATION SHOULD BE EMAILED TO OHIOHEALTH AT OHAccountsPayable@OhioHealth.com