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: _____

Vendor 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 credit card

Authorization:

I certify that the above information is true and correct, and that as a representative for the above named company, I hereby authorize OhioHealth to electronically deposit payments to the designated bank account. This authority remains in force until OhioHealth receives a signed form requesting a change or cancellation.

Printed Name: _____ Title: _____

Signature: _____ Date: _____

Completed by OhioHealth

Pay Code: _____

AP Signature: _____

SCIS Signature: _____

DIG Signature: _____