

State of Colorado
**AUTHORIZATION AGREEMENT
FOR AUTOMATIC DEPOSITS (ACH CREDITS)**

Agency ID UHA

Check one:

New Change

I (we) hereby authorize the Department of Health Care Policy & Financing, State of Colorado, hereinafter called STATE, to initiate credit entries and, if necessary, reverse any incorrect EFT credit entries made in error to our bank account indicated below.

MEDICAID PROVIDER # _____

NATIONAL PROVIDER IDENTIFIER # _____

PROVIDER LEGAL NAME _____

PROVIDER DBA NAME _____

Complete one of the following (EIN or SSN) but not both

FEDERAL EIN NUMBER

(Corporation, partnership, trust, sole proprietor, etc.)

_____ - _____

SOCIAL SECURITY NUMBER

(Individual or sole proprietor)___

_____ - _____ - _____

ADDRESS _____

CITY, STATE, ZIP _____

FINANCIAL INSTITUTION INFORMATION

FINANCIAL INSTITUTION NAME _____

FINANCIAL INSTITUTION ADDRESS _____

CITY, STATE, ZIP _____

FINANCIAL INSTITUTION TRANSIT NUMBER _____

ACCOUNT NUMBER _____

TYPE OF ACCOUNT (CHECK ONE)

CHECKING

Attach voided check or bank letter

SAVINGS

Attach bank letter

This agreement is to remain in full force and effect until the STATE has received written notification from the PAYEE of its termination in such time and manner to afford STATE and FINANCIAL INSTITUTION a reasonable opportunity to act on it. It is the responsibility of the PAYEE to fill out a new agreement if the PAYEE changes banks or accounts.

Date _____ Phone number _____

Authorized Signature _____

Print Name _____

Title _____

Other contact name _____ Phone number _____

