

# ACH Enrollment Form

For your convenience and benefit, TriHealth EAP offers payees the opportunity to receive payments electronically rather than by check. In addition to having the money deposited electronically, you will also be notified of the deposit electronically, by either fax or email. The fax or email will provide you with all the information that would normally be on your check stub.

## ELECTRONIC PAYMENT AUTHORIZATION

### I. VENDOR INFORMATION

Vendor Name: \_\_\_\_\_

Vendor Address: \_\_\_\_\_

\_\_\_\_\_  
City ST Zip

Contact: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Tax Identification #: (Fed #) \_\_\_\_\_ or (SS#) \_\_\_\_\_

### II. DEPOSITORY INFORMATION

Depository Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
City ST Zip

Contact: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Account Type:  Checking  Savings

Bank Transit Routing #: \_\_\_\_\_ Account #: \_\_\_\_\_

### III. NOTIFICATION OF PAYMENT

Remit will be mailed if no fax or email is provided. TriHealth will send the remittance to you by:

Fax: (\_\_\_\_) \_\_\_\_\_ or Email: \_\_\_\_\_

### IV. CERTIFICATION

*I authorize TriHealth to make electronic deposits to the account listed above. I certify that the information above is correct. I agree to provide TriHealth written notice 10 days prior to revocation of this authorization.*

\_\_\_\_\_  
Vendor Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Vendor Name (Printed)

\_\_\_\_\_  
Date

Remit to: TriHealth Corporate Health Billing  
4665 Cornell Rd., STE 350 Cincinnati, OH 45241  
Secure Email: trihealthapbilling@trihealth.com  
Secure Fax: 513-852-8533