Electronic Fund Transfer Authorization

~ To establish electronic payments transferred to your bank account, please **complete** this authorization form.
~ For validation purposes, **CSH** requires a **VOIDED** check. We do not accept deposit slip or cancelled check.
~ Please ensure that the information is **accurate** to avoid payment delays.
~ If any of the information changes, please **notify CSH** AP Department immediately and submit an updated EFT form and voided check, if applicable.

Applicant Name _____

Account Name _____

Financial Institution Name _____

City _____ State _____

Routing Number (must be 9 digits) _____

Account Number _____

Email Address _____

Authorization

I hereby authorize **Clear Spring Health** to deposit all payments due me to the depository Financial Institution and bank account indicated above.

The undersigned states: Entering my name below constitutes my electronic signature and is intended by me to have legally binding effect. By signing in this manner, I am assenting to the terms and conditions of this document in the same way as if I had provided my signature manually upon this document.

Signature _____ Date _____

Please complete and email this form to CSH Accounts Payable Department:
AP.Invoice@ClearSpringHealthcare.com
or fax to **847-692-3225**