



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: _____

PLEASE SEND THE FOLLOWING WITH YOUR ACH ENROLLMENT FORM:

- 1) a current, completed and signed W-9
- 2) a voided check from your account or a letter from your bank to confirm your bank account and routing #

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