SCL Health

ACH ENROLLMENT FORM

VENDOR NAME: _____

DATE: _____ **FEDERAL TAXPAYER ID:** _____

ACCOUNT STATUS: ☐ Set up new account ☐ Change account profile

BANK INFORMATION

We would like our disbursements paid via ACH and deposited in the following bank account:

Account Type: ☐ Checking ☐ Savings

Bank Name: _____

Bank Routing Number: _____

Bank Account Number: _____

Bank Address: ***Street*** _____

City _____

State _____ ***Zip code*** _____

- - - - - Please be sure to attach a voided check - - - - -

Emails will be sent to the following designated vendor contact with remittance advice.

CONTACT INFORMATION

Contact Name: _____

Phone Number: _____ **Fax Number:** _____

Email Address: _____

SCL Health desires the flexibility to make payments for goods and/or services by electronic funds transfer (EFT) through the ACH Network. VENDOR agrees to grant such flexibility. Therefore, VENDOR hereby (1) authorizes SCL Health to make payments for goods and services by EFT, (2) certifies that it has selected the above depository financial institution and (3) directs that all such electronic funds transfers be made as provided above. VENDOR agrees that in the event of an error, SCL Health has the right to reverse the transaction. Vendor will notify SCL Health of any changes in depository financial institution or other payment instructions 15 days in advance. Vendor acknowledges and agrees that the terms and conditions of all agreements or purchase orders with SCL Health and/or affiliates concerning the method of payments shall be amended as provided herein. VENDOR will be provided remittance data via email.

Authorized by: _____ Phone Number: _____
(Print name)

Signature: _____ Date: _____

This section to be completed by SCL Health APSS Department					
Date Received:		**Date ACH Active:**		**Date Vendor Notified:**	

Mail to: SCL Health, Attn. Accounts Payable, PO Box 1010, Lafayette, CO 80026 – or –
Email as PDF to: ACHEnrollment@SCLHS.net