CalOptima Health

for CalOptima use only

VENDOR ID	

Return Completed Form to:
Accounting Department — CalOptima | ach.vendors@caloptima.org

Electronic Funds Transfer Authorization Form

ACTION REQUESTED

☐ NEW ☐ CHANGE

Vendor Name		*SSN/TIN#*
Legal Business Name (if applicable)	*Email Address:*	*Contact Phone Number:*
Address		
City	*State*	*ZIP Code*

VERIFY ROUTING NUMBER WITH FINANCIAL INSTITUTION (MUST PROVIDE LETTER FROM FINANCIAL INSTITUTION FOR VALIDATION)

IF "CHANGE" IS SELECTED AS ACTION REQUESTED, MUST FILL OUT BOTH CURRENT AND NEW BANK INFORMATION:

CURRENT BANK NAME		*CURRENT BANK ADDRESS*	*CITY*
STATE	*ZIP CODE*	*PHONE NUMBER*	*FAX NUMBER*
CURRENT ROUTING NUMBER		*CURRENT ACCOUNT NUMBER*	*TYPE OF CURRENT ACCOUNT (CHECKING/SAVING)*
NEW BANK NAME		*NEW BANK ADDRESS*	*CITY*
STATE	ZIP CODE	*PHONE NUMBER*	*FAX NUMBER*
NEW ROUTING NUMBER		*NEW ACCOUNT NUMBER*	*TYPE OF NEW ACCOUNT (CHECKING/SAVING)*

I, the vendor, certify that the above information is true, accurate and complete to the best of my knowledge. I understand that incorrect or inaccurate information may affect my eligibility to receive payment through electronic funds transfer. I also understand that I must notify CalOptima immediately of any changes in the above information. I further declare that I will abide by all applicable Federal and State laws and regulations, as well as all applicable CalOptima Policies and Procedures, including any additions, deletions or changes thereto. This authorization will remain in full force and effect until CalOptima receives advanced written notification from me of its termination, or until CalOptima or a regulatory authority determines that it is necessary to terminate this agreement. By signing this agreement, I acknowledge that payments issued hereunder will be from federal and state funds, and that any falsification or concealment of a material fact may result in prosecution under applicable federal and/or state laws.

PLEASE SELECT ONE

☐ **I hereby authorize the Orange County Health Authority, doing business as CalOptima, a County Organized Health System, to initiate credit entries to my bank account as indicated above, and for the depository named above to credit the same to such account.**

☐ **I hereby cancel my Electronic Fund Transfer authorization.**

PRINT NAME	*TITLE*	*SIGNATURE (must be owner or corporate officer)*	*DATE*