Vendor ACH Enrollment Form

To participate in Interim Physicians, LLC's ACH program:

1. Fill in the requested information
2. Attached voided check(s) for verification of bank information
3. Sign the form and return to Interim Physicians, LLC Accounting Department, either by:
    a. Fax: (800) 865-3564, or
    b. Email: worklogs@interimphysicians.com

Vendor/Provider Name:	
Federal Taxpayer ID Name:	
Federal Taxpayer ID #:	
Phone Number:	

CHECK ONE OF THE FOLLOWING:

☐ New authorization ☐ Changing bank(s) ☐ Cancel ACH enrollment ☐ Changing ACH amount

Bank Information

Bank Name:	
Bank Phone:	
ABA/Routing #:	
Account #:	
Account Type	☐ Checking ☐ Savings

PLEASE CALL YOUR BANK TO VERIFY ABA/ROUTING AND ACCOUNT NUMBERS

I authorize Interim Physicians, LLC and the bank named above to deposit funds directly to the account(s) listed above. I further authorize Interim Physicians, LLC to make any adjustments for deposit errors which may occur (including withdrawal of funds from my bank account(s) in the case of overpayment). This authority will remain in effect until it is canceled in writing.

Signed____ Date____________________

ATTACH VOIDED CHECK HERE