AltaPointe Health
Your well-being is our priority.

Vendor Information
ACH Authorization Form

Select One:			
	New		Change
Account Type			
	Checking		Savings

Section 1 - Vendor Information

Name (Printed):	Premier Vendor Number:	Contact Name:
Street Address:		
City:	State:	Zip Code:
E-mail Address (for notification of direct deposit):		Phone Number:

Section 2 - New Financial Institution Information

Name:		
Street Address:		
City:	State:	Zip Code:
Exact Depositor Account Name:		
Nine-Digit Routing Transit Number:	Account Number:	

Section 3 - Existing Financial Institution Information (when requesting banking information change)

Name:		
Street Address:		
City:	State:	Zip Code:
Exact Depositor Account Name:		
Nine-Digit Routing Transit Number:	Account Number:	

Section 4 - Signature and Other Information

By submitting this form, I certify that the information provided on this form is correct and understand that I am responsible, upon receiving notification of deposit, for verifying with my bank that my account has been credited. I understand that expendatures made from my account without such verification will be made at my own risk. I agree promptly to notify AltaPointe Health Purchasing and Accounts Payable Department of changes in my name, address, and/or account status. I authroize the financial institution named above to process the credit entires initiated by AltaPointe Health. I understand that this authorization remains in full force and effect while I am a vendor for AltaPointe Health unless AltaPointe Health receives my timely written request to terminate or unless AltaPointe Health notifies me that EDD or my participation in EDD is to be terminated.

Printed Name:	Title:
Authorized Signature:	Date:

Please complete and return this form to the Accounts Payable department via e-mail at ap@altapointe.org or mail to AltaPointe Health, Attn: Accounts Payable, 5750-B Southland Drive, Mobile, AL 36693