



Authorization Agreement for ACH Payments

Vendor Name _____
hereby authorizes Capital District Physicians' Health Plan, Inc. (CDPHP) to initiate credit entries to our checking account indicated below at the depository named below, through the Automated Clearing House process.

Depository Bank

Name _____

Address: _____

City _____ State _____ Zip _____

Routing Number _____

Account Number _____

Account Name _____

Federal Tax ID # _____

Payment will not be direct deposited until a test ("pre-note") has been successfully completed to verify the accuracy of the information provided to the disbursing bank. Payments are made weekly and transmitted to the disbursing bank on Thursday, unless there is a holiday in which case the payment will be sent the preceding business day.

Preferred method for payment notification (please indicate one):

____ Faxed copy of statement to fax # _____

____ Copy of statement sent via U.S. Postal Service to:

Return form to:

Fax: (518)641-4006 ATTN: Accounts Payable
Mail: CDPHP
Accounts Payable Department
500 Patroon Creek Blvd.
Albany, NY 12206