AUTOMATED CLEARING HOUSE (ACH) REQUEST FORM

Vendor Information:

Vendor Name: _____

Remittance Address: _____

Remittance City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone #: ( ) _____

E-Mail Address: _____

Banking Information:

Vendor's Bank Name: _____

Bank Address: _____

Bank's City: _____ State: _____ Zip Code: _____

Bank Contact Name: _____ Phone #: ( ) _____

ABA Routing #: _____ Account #: _____

Account Type
(please check only one) Checking ☐ Savings ☐

Vendor's Authorization:

Please sign below to confirm that you are authorizing Arizona Alliance for Community Health Centers (AACHC) to begin transferring payments for your invoices to the account mentioned above.

_____ _____
Signature Title

( ) _____ _____
Phone Number Date

Please submit the completed form and a copy of a voided check or a letter from your bank providing confirmation of your account information.