DIRECT DEPOSIT/ACH AUTHORIZATION FORM

Complete the required information below to enroll, change, or cancel your current direct deposit at Chinese Community Health Plan and/or Jade Health Care Medical Group.
The following documents must be attached to this form:

- Voided Check (Checking Accounts Only)
- Completed and signed W-9 Form. Provider's business name must be identical to the bank account name and EIN/TIN.

I. Provider Information	(Please Print Legibly)
Provider Name	Employer/Tax Identification Number (EIN or TIN)
Business Name of DBA	Address
City	State
Zip Code	Phone Number

II. Direct Deposit Information	Circle One: New Change Cancel
Account Holder Name	Checking Account #
Bank/Financial Institution Name	Bank Routing #
Bank Address	City
State	Zip Code

III. Authorizations

1. By signing this agreement, I authorize Chinese Community Health Plan (the Plan) and/or MSO to automatically deposit my claim payment into my account(s) each payday. The Plan and/or MSO reserves the right to recall or adjust any deposits improperly created and deposited to my account. I understand my direct deposit service may be suspended or rescinded by the Plan and/or MSO at any time.
2. It is my responsibility to notify the Plan and/or MSO of any account closures or changes. If the direct deposit is not stopped before closing an account, I agree to wait until the funds are returned to the Plan and/or MSO to receive my funds. This could take several weeks and will delay my payment.
3. I understand I may revoke my direct deposit authorization at any time by providing written notification to the Plan and/or MSO.
4. It is my responsibility to ensure that my claim payment is properly credited to my account before issuing any debits against my account. I will hold the Plan and/or MSO harmless for any liability to pay charges for insufficient fund transactions that result from failure within the Automated Clearing House Network to correctly and timely deposit monies into my account.
5. I agree to hold harmless and indemnify Chinese Community Health Plan and their employees, authorized personnel, from any claim or demand of whatever nature, including those based upon negligence, brought by any person, including any financial institution for failure or delay in making deposits and/or corrections to deposits as herein authorized. This authorization replaces any previously made by me and remains in effect until I cancel or submit a new authorization.

Signature:	Date:

Once completed, return this form via **email, fax, or mail**:

Email to both:

- Kai Chow, Accounting Clerk: Kai.Chow@CCHPHEALTHPLAN.COM
- Ben Strong, Interim Director of Claims: Ben.Strong@CCHPHEALTHPLAN.COM

Fax:

- 415-955-8817
  Attn: CCHP Finance Department

Mail:

- CCHP Finance Department
  445 Grant Avenue, Suite 700
  San Francisco, CA 94108