Ozarks Medical Center
The Right Care, Right Here

ACH PAYMENT ENROLLMENT FORM

New enrollment _____ Change _____ Effective Date _____

PAYEE INFORMATION	
NAME	TAXPAYER ID NO. OR SOCIAL SECURITY NUMBER (REQUIRED):
ADDRESS	
CITY STATE ZIP	
CONTACT PERSON NAME	**TELEPHONE NUMBER/EMAIL ADDRESS**

FINANCIAL INSTITUTION INFORMATION	
NAME	
ADDRESS	
CITY STATE ZIP	TELEPHONE NUMBER
NINE-DIGIT ROUTING TRANSIT NUMBER	
ACCOUNT NUMBER	
TYPE OF ACCOUNT (please circle) Checking Savings Lockbox	
SIGNATURE AND TITLE OF AUTHORIZED OFFICIAL: (MUST BE AN AUTHORIZED SIGNER ON ACCOUNT)	DATE

Return this form to:

MAIL:
OZARKS MEDICAL CENTER
ACCOUNTS PAYABLE
PO BOX 1100
WEST PLAINS, MO 65775

FAX: 417-257-5806

EMAIL: accountspayable@ozarksmedicalcenter.com

By enrolling in ACH payments with Ozarks Medical Center, I agree to accept payment for services rendered or goods provided directly into my account listed above at the named financial institution. I agree to provide Ozarks Medical Center with complete and accurate information and of any changes to my financial deposit information. In the event that funds are erroneously deposited into said account, I authorize Ozarks Medical Center and the financial institution to initiate the transactions necessary to correct the error. I agree to release Ozarks Medical Center from any responsibility if funds are deposited to an incorrect account as a result of incomplete, inaccurate, or outdated information provided to Ozarks Medical Center. I further understand that any changes to my financial deposit information or the intent to terminate this agreement must be provided to Ozarks Medical Center in writing at least five (5) business days in advance of the effective date of the change.

_____ _____

Signature and Title Date

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INSTRUCTIONS

To enroll in the program, please complete the "ACH Payment Enrollment Form," on the back side of this page as follows:

1. Complete the "Payee Information" section of the form.

2. Email address is required to receive remittance information. The day the ACH payment is processed you will receive notification via email, included will be a list of invoices with amounts that the payment should be applied to. No paper remittance advice will be provided.

3. Complete the "Financial Institution Information" section. **The signature in this section must be an authorized signer on the account the money will be deposited into.**

4. Make a copy of the completed form for your files.

5. Return the completed original form to Ozarks Medical Center. Mail, fax, or email the form using the contact information at the bottom of the form**. If you return via email, the form must be in PDF form; any editable formats of the form will NOT be accepted.**

PLEASE NOTE:

1. It is your responsibility to notify Ozarks Medical Center if your banking information changes (i.e., you change account numbers, banks, etc.)

2. Changes to ACH information must be provided 5 business days in advance of payments. Changes submitted in less than 5 business days of payment date are not guaranteed to be made and could result in a delay of your payment.

3. Changes must be completed in writing. Under **NO** circumstance will verbal changes to banking information or preferred method of payment be accepted.

For questions or assistance with the form, please contact our Accounts Payable Specialist, Sandra Phenix at 417-257-5803 or at accountspayable@ozarksmedicalcenter.com