Attachment B Arkansas Department of Health

Authorization for Automatic Electronic Funds Deposit

Provider Legal Business Name: _____Provider #: _____

Doing **B**usiness **as** Name: _____

Provider Address: _____ _____Telephone:(___) _____

City, State: _____Zip: _____

Type of Authorization: Same ☐ Change ☐ New ☐

For verification purposes, please complete the following:

Routing Transit # :_____ Bank Account #:_____

PLEASE ATTACH A COPY OF A BANK LETTER TO VERIFY THESE NUMBERS. The name on the voided check/deposit slip should match the name on the provider business name of DBA state above

Name of Depository Bank: _____

Depository Address: _____

City, State: _____ Zip Code: _____

I hereby authorize the Arkansas Department of Health, *Breast*Care to initiate credit entries to the account indicated above and the depository named above to *credit* the same to such account. I understand that I am responsible for the validity of information on this form.

I understand in endorsing this funds transfer that payment will be from Federal and State funds and that any falsification or concealment of a material fact may be prosecuted under Federal and State Laws.

Arkansas Department of Health BreastCare will send the direct deposit to the Depository indicated above until notified by me that I wish to change the Depository receiving the direct deposit. If my Depository information changes, I agree to submit to BreastCare an updated Automatic Authorization Agreement.

Authorized Official Name (*Print*): _____

Authorized Official Title: _____

Authorized Official Signature: _____Date: _____

Please return this form to:
Arkansas Department of Health
BreastCare
4815 West Markham, Slot 11
Little Rock, AR 72205