ACH Vendor/Supplier Payment Enrollment Form

This form is used for Automated Clearing House (ACH) payments with an addendum record that contains payment-related information processed through EmblemHealth's Commissions Department.

All information collected in this form is required and will be used by EmblemHealth to transmit payment data by electronic means to vendor's financial institution. Failure to provide requested information may delay or prevent the receipt of payment through the ACH payment system.

Instructions/Contact Information

This form must be filled out in its entirety. The original completed and signed form should be emailed to **eftbrokercommissions@emblemhealth.com**.

Payee/Company Information

Broker Code:		License Number:	
Name:		SS# or Taxpayer ID #:	
Remit Address:	City:	State:	ZIP:
Contact Person's Name:	Telephone #:	Contact Person's Email:	
Contact Signature:		Email for Deposit Advice:	

Financial Institution Information

Name:			
Address:	City:	State:	ZIP:
ACH Coordinator Name: (Financial Institution Rep.)		Telephone #:	
Nine Digit Routing Transit#:		Depositor Account Title:	
Depositor Account #:		Type of Account: ☐ Checking ☐ Savings VOIDED CHECK REQUIRED	