HEALTH RESEARCH INCORPORATED

Clear Form

Vendor ACH Authorization Form

1. Please Check One:		
◯ NEW ACH **	◯ CHANGE ACH **	◯ CANCEL ACH

2. Vendor/Payee Information
Name:
Address:
Contact Person's Name (if other than payee):
Telephone Number:
Email Address:

3. Financial Institution Information		
Bank Name:		
Bank Address:		
Name on Bank Account:		
Bank Account Number:		
Nine-Digit Bank Routing/Transit Number (ABA):		
Type of Account:	◯ Checking	◯ Savings
** Included with all new or change submissions:	◯ Original voided check, or	◯ Original bank letter

4. Approvals/Authorizations - I certify that the information provided on this form is correct, and I hereby authorize Health Research, Inc. to electronically deposit payments to the bank account designated above. It is my responsibility to notify HRI (Businessops@healthresearch.org) immediately if I believe there is a discrepancy between the amount deposited to my bank account and the amount of the invoice(s) paid. I understand that I must notify HRI in writing immediately of any changes in status or banking information. I understand that this authorization will remain in full force and effect until HRI has received written notification requesting a change or cancellation and has had reasonable opportunity to act on it, which should take no longer than seven (7) to ten (10) business days.

Print Name: _____ Signature: _____ Date: _____

Form Submission
Please return completed form via email to: Businessops@healthresearch.org

For HRI Use Only:			Date Stamp - Received
	Signature:	Date:	
Entered By:			
Approved By:			

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