

 **CENTRAL VERMONT MEDICAL CENTER**
Member of  **DARTMOUTH-HITCHCOCK ALLIANCE**

MAILING ADDRESS - P.O. BOX 547, BARRE, VT 05641
DELIVERY ADDRESS - 130 FISHER ROAD, BERLIN, VT 05602

Vendor ACH Payment Authorization:

I hereby authorize Central Vermont Medical Center (CVMC) to initiate, through the automated clearing house (ACH), accounts payable payments, credit memos and, if necessary, adjustments for payments made in error for the business account indicated below. I understand CVMC complies with NACHA standards and rules. I also understand that CVMC will send a zero dollar transaction (pre notification) that includes Records 5, 6, 7, & 8, and CVMC will only begin making payments via ACH after I confirm, to CVMC, that our bank has received an error free zero dollar transaction.

BANK ACCOUNT INFORMATION

Please complete all fields

Business Name: _____

Business Telephone ##: _____ () _____

Name on Account(if different): _____

Business Checking Account Number: _____

Bank ABA Routing Number: _____

Name of Financial Institution: _____

Bank address line 1: _____

Bank address line 2: _____

City and State: _____ Zip Code: _____

Company Contact: _____

Contact Telephone ##: _____ () _____

Contact FAX Telephone ##: _____ () _____

Contact Email Address: _____

Authorized Signature: _____

Name and Title of Authorized Signor: _____

Date Signed (MM/DD/YYYY): _____

My signature confirms I am authorized by the above named company to enter this agreement.

Please send us the signed original form along with a VOID check for the account listed above.

Questions regarding this form or the status of ACH payment transactions should be directed to the accounts payable department at the address/number below.

CVMC Accounts Payable Office

Telephone 802 371-4219 or 4218

FAX 802 371-4802

Dept Email: CVMC.acctdept@hitchcock.org

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