EmblemHealth®

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 Accounts Payable System. Recipients of this form should bring this information to the attention of their financial institution when presenting this form for completion.

**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, along with a completed IRS W-9 Form, should be submitted to the attention of:

EmblemHealth Accounts Payable Department
Attn: Electronic Payments
55 Water Street
New York, NY 10041

Questions: Steve Amoroso **1-646-447-7809**
Email completed forms to **APVENDOR@emblemhealth.com**

Payee/Company Information:

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:	

CFO/Controller/COO Information:

Name:	Title:
Signature	Email:

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	

EmblemHealth Accounts Payable Use Only:

VENDOR NUMBER	COMPLETED BY: (Print)	DATE

RESET PRINT