Clear Form

MONTGOMERY COUNTY HOSPITAL DISTRICT

☐ New ☐ Updated

ENROLLMENT AND AUTHORIZATION FOR PAYMENT VIA ACH/EFT

MCHD Accounts Payable

Email completed and signed form, or any related questions to *ach@mchd-tx.org*.

Vendor Number*: _____

* *(Can be found on check remittance stub. See instructions on page 2. If no previous payments have been issued, write "New Account")*

Payee Information

Supplier Name:	
Address:	
City:	
State:	
Zip:	

Supplier Contact Name:	
Supplier Contact Number:	
Remittance E-Mail:	
Alternate E-Mail:	

Banking Information

Type of Bank account (checking or savings)	
Bank Name:	
Bank Address:	
Bank City, State and Zip code:	
Routing Number: (See instruction below)	
Account Number: (see instruction below)	
Re-Type Account Number:	

Provide an email address for payment notification: _____

I hereby authorize Montgomery County Hospital District to automatically deposit payments to the account listed above. I certify that I am authorized to enter into this agreement on behalf of the account holder. I verify that the information provided on this form is accurate.

Supplier Authorized Signature: _____ **Date:** _____

Printed Name: _____ **Title:** _____

Phone Number: _____ **Email:** _____

Accounting Department Use Only			
Verified Bank Data with Vendor:		**Date:**	
Financial Information Added by:		**Date:**	
Reviewed by:		**Date:**	

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