General Assistance Behavioral Health Program
Recovery Support Program
Authorization Agreement
For Electronic Funds Transfer (EFT)

☐ **NEW** ☐ **CHANGE OF INFORMATION**

INSTRUCTIONS:

This form should be completed by providers who wish to participate in the GA BHP/RSP electronic funds transfer (EFT) option. All of the fields indicated below are required and incomplete forms will be returned to providers.

Company Name: _____ Tax Identification Number: _____

I (we) hereby authorize **Advanced Behavioral Health, Inc.,** to initiate credit and, if necessary, debit entries and adjustments for any credit entries in error to my (our): (select one) ☐ Checking Account or ☐ Savings Account indicated below, at the depository Financial Institution named below, and to credit or debit the same from such account. I (we) acknowledged that the authority will remain in effect until I (or We) have cancelled it in writing and that the origination of EFT transactions to my (our) account must comply with the provisions of U.S. law.

Financial Institution: _____ Branch: _____

City: _____ State: _____ Zip Code: _____

Routing Number: _____

Account Number: _____

Email for notification of release of payment: _____
(Email address)

This authorization is to remain in full force and effect until Advanced Behavioral Health, Inc had received written notification from me (or either of us) of its termination in such time and in such manner as to afford company and the financial institution a reasonable opportunity to act on it.

Name: _____ Title: _____
(Please Print)

Phone: _____ Email: _____

Signature: _____ Date: _____

Please fax completed form along with a copy of a voided check to:
ABH® Provider Relations, 860-704-6145
Questions about the form, call 860-704-6440