**Electronic Funds Transfer Authorization**

**\*\*\* Please include a copy of a voided check to ensure Routing and Account numbers are correct\*\*\***

This form is an authorization agreement for Automated Clearing House pre-authorized corporate payments.

The undersigned hereby authorizes Oakland Physician Network Services to originate credit entries via the Automated Clearing House to the account indicated below at the Depository Financial Institution named below, to accept and to credit the amount of such entries to the account.

Bank Name:

Bank Contact Name:

Bank Address:

Bank City/State/Zip Code:

Bank Address:

Bank Transit ABA Number:

Bank Account Number:

This authorization will remain in effect until written notification of termination has been given by the customer and that notification has been received by Oakland Physician Network Services. OPNS, in its discretion, may terminate the customer’s ability to participate in the Electronic Funds Transfer system.

Grantee Name:   
as shown on bank  
account.

Grantee Tax ID:

Authorized Signature