Community Behavioral Health

801 Market Street, 7th floor, Philadelphia, Pa 19107

Direct Deposit Agreement Form

Authorization Agreement

I hereby authorize **Community Behavioral Health** to initiate automatic deposits to my account at the financial institution named below. I also authorize **Community Behavioral Health** to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold **Community Behavioral Health** responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until **Community Behavioral Health** receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Accounting Operations Department.

Account Information

Name of Financial Institution: _____

Routing Number: _____ Checking ☐

Account Number: _____ Savings ☐

Provider Information and Signature

Four Digit Parent ID	Fed ID#
Provider Name:	
Provider Address:	
Authorized Signature: CEO, President or Executive Director	
Print Name:	Phone #:
Title:	
Authorized Bank Signer: (Only if different from above)	Date:
Print Name:	Phone #
Title:	
Authorized Bank Signer Address: (Only if different from above)	

CBH Accounting Operations
801 Market Street, 7th Floor
Philadelphia, PA 19107

Please attach a voided check or a letter from your bank and return this form to the Accounting Operations Department