KAISER PERMANENTE®

Electronic Payment Enrollment

Kaiser Foundation Health Plan, Inc.
Electronic Commerce Department
Parsons East, 4th Floor
75 N. Fair Oaks Avenue
Pasadena, CA 91103

Instructions:

Application must be completely filled out (with the exception of one optional). Please email completed application to KP-AP-ACH@kp.org .

Company Information

Name:		Federal Tax ID:
Address:		
City:	State:	Zip Code:

Accounts Receivable Contact Name:	Email:
Phone #:	Fax #:

(Optional)

EDI/EFT Contact Name:	Email:
Phone #:	Fax #:

I hereby authorize Kaiser to initiate direct deposit of accounts payable disbursements into the account specified below and agree to work with Kaiser to recover any payment(s) made to our account in error.

Financial Institute Information

Bank Name:		
Address:		
City:	State:	Zip Code:

Bank Contact:	
Phone #:	Fax #:

ABA Transit Routing #:
Bank Account:

Account Type: ☐ Checking ☐ Savings

ACH Payment Format:

☐ CTX (EDI X12 / 820, Electronic remit translation by bank) ☐ CCD + Direct Deposit (Standard deposit without remittance)

Email Remittance: (provide single group email box)

Email:

AUTHORIZATION

I certify that the above information is true and correct, and that as an authorized signer of the above named company, I hereby authorize Kaiser Permanente to electronically deposit payments to the designated bank account. This authority remains in force until Kaiser Permanente, Accounts Payable Department, receives formal notification requesting a change or cancellation.

Printed Name of Authorized Signer:
Signature of Authorized Signer (handwritten signature required):
Title of Authorized Signer:
Date: