DENVER HEALTH
Level One Care for ALL

ELECTRONIC PAYMENT INFORMATION REQUEST FORM

(Please use one form for EACH remittance address)

Denver Health & Hospital Authority's (DHHA) preferred method of payment is via electronic funds transfer (EFT) to an account specified by the vendor. All vendors are requested to complete this form, and in doing so, authorize DHHA to direct payment to the account identified. All vendors may change the account to which payments are directed by submitting a new copy of this form. DHHA will attempt to redirect all payments to the new account within thirty days of receiving a new form. DHHA has five calendar days to reverse an incorrect payment. In order to receive an EFT payment in a timely manner, please submit this form within ten business days of receipt. If you have previously provided this information, please disregard this request.
Upon completion, please submit this form to:

Denver Health & Hospital Authority
Managed Care Division
777 Bannock Street, MC 6000
Denver, CO 80204-6000
Attn: Provider Relations Department

or

fax to (303) 602-2096, Attn: **Managed Care Provider Relations Rick Muhammad**

e-mail to Rick.Muhamma@dhha.org

The EFT information you provide will be associated with the remittance address filled in on this form. If your remittance address different than the one filled in on the form, please provide the correct remit address that will be on the invoices you send.

Vendor Name: _____

Tax ID Number: _____

Remit Address: _____

_____

Name of Your Bank: _____

Bank Address: _____

Bank Ranking (ABA) Number: _____

Account Name: _____

Account Number: _____

Account Type (select one): Checking _____ ***OR*** Savings _____

Individual Authorized to Release this Information:

Name: _____

Phone #: (_____) _____-_____ Title:

_____

Signature: _____

Your Company Contact:

Name: _____

Phone #: (_____) _____-_____ Title: _____

Method of Receiving Remittance Advice:

The primary method of notification of payment will be via Email.

Please complete the following sections so that DHHA has the appropriate information.

Email:

_____

FAX: (_____) _____-_____

*For use by DHHA only: Vendor#*_____