AUTHORIZATION FOR PAYMENT VIA ELECTRONIC FUNDS TRANSFER (EFT)
(Formerly Direct Deposit)

(LEGAL ENTITY NAME - PLEASE PRINT)

(TAX ID) OR (SOCIAL SECURITY NUMBER)

I authorize Community Care to initiate entries to the above named entity's Checking/Savings account(s) indicated below and the financial institution named below to credit and/or debit the same to such account.

(CONTACT NAME – PLEASE PRINT) (TITLE)

(SIGNATURE) (DATE)

(NAME OF FINANCIAL INSTITUTION) (BRANCH)

(CITY) (STATE) (ZIP CODE)

☐ CHECKING ☐ SAVINGS

(ACCOUNT NUMBER)

(FINANCIAL INSTITUTION ROUTING NUMBER)

This authority is to remain in full force and effect until Community Care has received written notification from the above company in such time and in such manner as to afford Community Care and the financial institution named above a reasonable opportunity to act on it.

Return this form and a cancelled or voided check to:
Community Care, Inc.
ATTN: Provider Management
1801 Dolphin Drive
Waukesha, WI 53186
Or
FAX: 262-446-6707
Or
E-mail: ContractInquiries@communitycareinc.org