Capital Health PLAN℠

An Independent Licensee of the Blue Cross and Blue Shield Association

MEDICARE New ☐
Change ☐

DRAFT BEGIN DATE: _____

FOR COVERAGE: _____

AUTHORIZATION AGREEMENT FOR AUTOMATED BILLING (ACH DEBITS)

Member Name:_____ **Member ID#:** _____
(please print)

I (we) hereby authorize Capital Health Plan, hereinafter called Company, and the depository named below, hereinafter called Financial Institution, to initiate debit entries and initiate, if necessary, credit entries and adjustments for any debit entries in error to my (our) Checking/Savings account.

Bank / Credit Union _____

Routing # _____ **Account #** _____

CHECKING ☐ **SAVINGS** ☐
(please check one above)

This authority is to remain in full force and effect until Company has received written notification from me (or either of us) of its termination in such time and such manner as to afford Company and Financial Institution a reasonable opportunity to act on it.

Withdrawals are done on the **10th** of the month for the invoice due. In the event the **10th** falls on a weekend or holiday, the draft will take place the following business day.

A VOIDED CHECK MUST BE ATTACHED TO THIS FORM

Date _____ **Signature** _____

Member Services
850-383-3311

H5938_DP 373 Accepted 08282012

This form can be dropped off in person at:
1264 Metropolitan Blvd Tallahassee, FL 32312

Or

FAX#: 850-523-5623
Email to: premiumbilling@chp.org