Accounts Receivable Contact Information
Cheri Klingenstein

Mailing Address: Altius Health Plans
P.O. Box 951537
Dallas, TX 75395-1537
Fax Number: (866) 635-9392

Voice Number: (888) 296-3337 ext. 4338

AUTHORIZATION AGREEMENT FOR ACH DEBIT

Company Name: ______________________________

Group Account Numbers: ______________________________

Bank Account Type: ☐ **Checking Account** ☐ **Savings Account**

Name on Account: ______________________________
(Please enter the name as it appears on the account to be debited)

Bank Name: ______________________________

Bank Address: ______________________________

Bank ABA Number: ______________ **Bank Account Number:** ______________

☐ I agree that this authorization will remain in effect until I provide written notification terminating this service. ACH transaction will occur on the 10th of the month in the amount of the balance due for the current month.
Mail completed form and a voided company check to your Health Plan Accounts Receivable Department (see top of page).

OR

☐ I agree to a one-time only authorization as described below:
(fax completed form to your Accounts Receivable Department, top of page).

Invoice Number(s)	Amount
Total Amount	
Effective Date of Transaction	

Signature: ______________________ Date: ______________
(authorized signature for bank account)

Print Name: ______________________ Phone: ______________

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