



Please Email or Fax a voided check with completed form to:  
Well Sense Health Plan

EMAIL: [Accounts.Payable@BMCHP-wellsense.org](mailto:Accounts.Payable@BMCHP-wellsense.org)  
FAX: 617-897-0886

## Vendor Authorization Agreement for Automated Clearing House (ACH) Payment

To be completed by vendor:

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Company Name ("vendor") Effective Date

Authorizes Well Sense Health Plan ) to make payments directly into vendor's account at the following Financial Institution and on the following

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Name of the Financial Institution Effective Date

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In the event of an overpayment, vendor agrees to issue a refund to BMCHP within 10 days upon receipt of the overpayment. An official vendor representative's signature on this form authorizes payments to the vendor through the ACH system. The information provided on this form will be used to transmit payment data by electronic means to the vendor's financial institution. It is understood that if there are any changes to vendor's account or vendor plans to cancel this agreement, then vendor is responsible for notifying BMCHP at least 15 days in advance so as to afford a reasonable opportunity to take action. Vendor shall be responsible for any loss which may arise by any error, mistake or fraud concerning the information vendor has provided in this agreement. All transactions under this agreement shall be governed by the rules of the New England Automated Clearing House. BMCHP may suspend this agreement at any time.

### Vendor's Company Information

Company Name: \_\_\_\_\_

Address, City, State, Zip: \_\_\_\_\_

Company Contact Name & Phone Number: \_\_\_\_\_

Remittance Notice Email Address: \_\_\_\_\_

Authorized Vendor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name and Title: \_\_\_\_\_

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### Vendor's Financial Institution Information

*This section to be completed only if a voided check is unavailable*

Financial Institution: \_\_\_\_\_ Account Name: ACH Services

Telephone Number: \_\_\_\_\_ Account Type: \_\_\_\_\_

9-Digit Routing Transit Number: \_\_\_\_\_ Account #: \_\_\_\_\_

Bank Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name and Title: \_\_\_\_\_ Phone #: \_\_\_\_\_

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