# Account Verification Form for Automatic Payment

TO: University Health System
CareLink – MS 29-2
4502 Medical Drive
San Antonio, TX 78229
Office: (210) 358-3350

FROM: ______________________________
(CareLink Member Name)
______________________________
(MRN)

***"I hereby authorize my financial institution to verify the information below for the purpose of establishing an automatic withdrawal for my CareLink account with the University Health System." Yo autorizo a mi banco que verifique la información con el deseo de establecer la transferencia de fondos para mi cuenta de CareLink con el University Health System.***

**ACCOUNT INFORMATION**: ***(To be completed by Financial Institution)***

______________________________________________________________________________
Account Holder's Name: Bank Account Number: Account Type

______________________________________________________________________________
Account Holder's Address: City State Zip

( ) ______________________________ ( ) ______________________________
Home Telephone Number Work Telephone Number

Financial Institution Name: ______________________________________________

ACH Routing Number: __________________ □ Checking □ Savings

***Financial Institution Representative Name/Stamp:***

______________________________________________________________________________

**Account Holder's Signature**: ______________________________________________

Rev: 03/2016 – CareLink Acct Verification Form