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: _____