SANTÉ PHYSICIANS

ACH AUTHORIZATION FORM

PAYEE NAME AND ADDRESS:

_____

_____

_____

Tax ID: _____

Does your Account Have an ACH Block: ☐ Yes ☐ No

Name of Bank: _____

Address of Bank: _____

Routing Number: _____

Account Number: _____

By signing this ACH Authorization Form ("ACH Form"), Payer Santé Physicians ("Payer") is authorized to credit or debit the account number listed above (the "Account") in connection with processing health plan payment transactions. Account Owner also agrees to be bound by National Automated Clearing House Association rules ("NACHA"). These rules provide, among other things, that debits and credits are provisional until final settlement is made through a Federal Reserve Bank or payment is otherwise made as provided in Article 4A-403(a) of the Uniform Commercial Code.

In addition, Account Owner agrees Payer may make adjustments to the Account whenever a correction or change is required. For example, if Payer makes an error with respect to a debit or credit, you agree Payer may correct such error immediately. The right to make such adjustments shall not be subject to any limitations or time constraints, except as required by law. Account Owner agrees that Payer may test the account by first crediting the Account in the amount not to exceed $1 and then debiting the same amount back. This will affirm the Account is set up properly. Further, the above banking institution will be given notice by the Account Owner to **REMOVE ANY DEBIT BLOCK OR DEBIT LIMIT** for Payer by providing a copy of this form to the financial institution listed above noting "**Origination Company ID: 1770246795."**

This ACH Form shall remain in effect unless and until Payer has received written notification from you indicating that your authorization and this ACH Form have been terminated in such time and manner to allow us to act. The undersigned represents and warrants that the person executing this ACH Form is an authorized Signatory on the Account referenced above and all information regarding the Account and Account Owner is true and correct.

_____
Signatory or Account Owner

_____
Print Name

_____
Title

_____
Date

- PROVIDE AN EXECUTED ACH AUTHORIZATION FORM COPY TO THE BANK LISTED ABOVE.
- RETURN AN EXECUTED ACH AUTHORIZATION FORM WITH A BANK LETTER OR AN ORIGINAL VOIDED CHECK (COPIES WILL NOT BE ACCEPTED) TO:

  SANTÉ PHYSICIANS
  ATTN: SP FINANCE
  7370 N. Palm Ave. #101
  Fresno, CA 93711

Bank Notification:

Remove any DEBIT BLOCK or DEBIT LIMIT for "Origination Company ID: 1770246795"