



Vendor Direct Deposit Authorization Advance Payment Notification Authorization

INSTRUCTIONS

- Use only BLUE or BLACK ink.
- Alterations must be initialed.
- Check all appropriate box(es).
- Keep a copy for your records.

For further instructions, see page 2.

TRANSACTION TYPE

SECTION 1	<input type="checkbox"/> New setup	Sections 2, 3, 4 & 5 (6 Optional)	<input type="checkbox"/> Change account number	Sections 2, 3, 4 & 5
	<input type="checkbox"/> Cancellation	Sections 2 & 4	<input type="checkbox"/> Change account type	Sections 2, 3, 4 & 5
	<input type="checkbox"/> Change financial institution	Sections 2, 3, 4 & 5		

VENDOR/PAYEE IDENTIFICATION

SECTION 2	1. Texas Identification Number: (PAYEE Number, SSN, or FEIN)				2. Mail Code: (Agency Use ONLY)			
	3. Vendor or payee name (Required)						4. Contact phone number (Optional) ()	
	5. Payment address (Required)			6. City (Required)		7. State (Req.)	8. Zip code (Req.)	

FINANCIAL INSTITUTION INFORMATION (Completion by Financial Institution is recommended.)

SECTION 3	9. Financial institution name (Bank name) (Required)				10. City		11. State	
	12. Routing transit number (9 digits)				13. Customer account number (maximum 17 characters)			
	14. Type of account				<input type="checkbox"/> Checking	<input type="checkbox"/> Savings		
	15. Financial representative name (Optional)				16. Title (Optional)			
17. Financial representative signature (Optional)				18. Phone number (Optional) ()		19. Date (Optional)		

AUTHORIZATION FOR SETUP, CHANGES OR CANCELLATION

SECTION 4	20. I authorize the Texas Comptroller of Public Accounts to deposit my payments from the state of Texas to my financial institution electronically. I understand that the Texas Comptroller of Public Accounts will reverse any payments made to my account in error.		
	I further understand that the Texas Comptroller of Public Accounts will comply at all times with the National Automated Clearing House Association's rules. For further information on these rules, please contact your financial institution.		
	21. Authorized signature (Required)	22. Printed name (Required)	23. Date (Required)

INTERNATIONAL PAYMENTS VERIFICATION (required)

SEC 5	24. Will these payments be forwarded to a financial institution outside the United States?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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AUTHORIZATION FOR ADVANCE PAYMENT NOTIFICATION SETUP (optional)

SECTION 6	25. By completing this section, I authorize the Texas Comptroller of Public Accounts to send a notification via e-mail, one business day prior to the payment setting in my account.
	Please indicate that you want to receive payment notification by providing an e-mail address: _____

CANCELLATION BY STATE AGENCY

SEC 7	26. Reason: <i>LEAVE BLANK - To be completed by State Agency Only</i>	27. Date
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Please return your completed to:

DEPARTMENT OF STATE HEALTH SERVICES
 DSHS Claims Unit MAIL CODE: 1940
 P.O. Box 149347
 Austin, Texas 78714-9347
 Phone Number (512) 776-7435

DSHS AGENCY USE ONLY
[Do Not Complete]

Processed: _____ Date: _____

Verified: _____ Date: _____

COMMENTS: _____

INSTRUCTIONS FOR DIRECT DEPOSIT AND ADVANCE PAYMENT NOTIFICATION AUTHORIZATION FORM

SECTION 1

Select the box for your request.

SECTION 2:

Fill in the blanks for box 1:

Individuals, enter your Social Security Number (SSN), or

Companies, enter your Federal Employer ID Number (FEIN).

Leave box 2 **blank**.

You must fill in boxes 3-8 with your name and address.

SECTION 3: (Completion by Financial Institution is Recommended)

Fill in boxes 9-19 with your bank account information.

If you need help, contact your bank.

SECTION 4

You **must** fill in boxes 20-23. Sign and print your name, and then date the form.

SECTION 5

If you receive state payments via direct deposit which are forwarded from a U.S. financial institution to a financial institution outside the U.S., please contact the Texas Comptroller of Public Accounts at (512) 936-8138 and fax your form to (512) 475-5424.

SECTION 6

If you want to know when your state payments are deposited into your account, fill in your email address.

You will receive the notice by e-mail one business day before the deposit.

SECTION 7

DO NOT FILL IN THIS SECTION. THIS SECTION IS FOR STATE AGENCY USE.

HOW TO SUBMIT YOUR FORM:

Mail the completed and signed form to the Department of State Health Services (DSHS) at this address:

DSHS Claims Unit
Mail Code 1940
PO Box 149347
Austin, TX 78714-9347

If you need to change something about your direct deposit, call DSHS at (512) 776-7435.

Kidney Health Care clients call 1-800-222-3986.

Keep a copy of this form for your records.

You have certain rights under Chapters 552 and 559, Government Code, to review, request, and correct information we have on file about you. Call 1-800-531-5441, ext. 68138.