

# Direct Deposit Authorization Form



**Please Sign & Fax or Mail To:**

AvMed Health Plans  
 Accounts Payable  
 P.O. Box 1778  
 Gainesville, FL 32602-1778  
 Fax (352) 337-8741

**Electronic Funds Transfer (direct deposit) of your payments DIRECTLY into your bank account!  
 We will also DELIVER your Remittance Advice directly to your fax number.**

PRINT BATCH 4,048	VENDOR CODE 00223452	PAY TO NAME	NET TOTAL
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Vendor code on check remittance advice

AvMed Inc. PO Box 1778 Gainesville, FL 32602-1778	Wachovia Bank 104 North Main Street Gainesville, FL 32601	63-1012/632
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Payee name (legal entity)	Vendor code	Tax Identification Number	
Fax # (for remittance advice)	Phone #	Contact: First and last name	
Bank name	Name on account	Routing number	Account number

ATTACH A VOIDED CHECK COPY  
 (voided check is optional)

Authorization is hereby given to AvMed Health Plans to credit said account at the financial institution named above for the purposes of transferring AvMed Health Plans payments. AvMed Health Plans is also granted authorization to correct funds erroneously deposited and other necessary debit/credit entlies. This authorization is to remain in effect until notification is given to AvMed Health Plans in writing (requires at least 10 days notice) on an AvMed Health Plans Direct Deposit Authorization Form advising of a change, allowing reasonable time to implement such changes.

**If you have any questions, please call AvMed Accounts Payable at (352) 337-8961.**

Authorized signature \_\_\_\_\_ Printed name and title \_\_\_\_\_ Date \_\_\_\_\_