

PAYMENT INFORMATION FORM ACH VENDOR PAYMENT SYSTEM

This form is used for the ACH payments with an addendum record that carries payment-related information. Recipients of these payments should bring this information to the attention of their financial institution when presenting this form for completion.

PAPERWORK REDUCTION ACT STATEMENT

The information being collected on this form is required under the provision of 31 U.S.C. 3322 and 31 CFR 210. This information will be used by the Treasury Department to transmit payment data by electronic means to vendor's financial institution. Failure to provide the requested information may delay or prevent the receipt of payments through the Automated Clearinghouse Payment System.

MEDICAL PROVIDER INFORMATION

Provider #:

Name:

Address:

Contact Person Name:

Telephone Number:

AGENCY INFORMATION

Name: DOL Federal Black Lung Program

Address: PO Box 13200

Tallahassee, Florida 32317-3200

Contact Person Name:

Telephone Number: 1-800-638-7072 Toll Free

FINANCIAL INSTITUTION INFORMATION

Name:

Address:

ACH Coordinator Name:

Telephone Number:

Nine-Digit Routing Transit Number: _____

Depositor Account Title:

Depositor Account Number:

Type of Account: Checking Savings

Signature and Title of Representative:

Telephone Number:

Please return complete forms via Mail or FAX to: **(850) 201-1718**
DOL Federal Black Lung Program, PO Box 13200, Tallahassee, FL 32317-3200
(Incomplete forms will cause a delay in processing and are subject to return).