Attachment 4

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: Division of Energy Employees' Occupational Illness Compensation	
Address: P.O. Box 8304	
London, KY 40742-8304	
Contact Person Name:	Telephone Number: 1 (866) 272-2682 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: