**ACH Authorization Form**

I (we) hereby authorize **OPTION CARE HEALTH/CLINICAL SPECIALTIES, INC**. to initiate entries to my (our) checking/savings account at THE FINANCIAL INSTITUTION listed below, and, if necessary, initiate adjustments for any transactions credited/debited in error. This authority will remain in effect until Option Care is notified by me (us) in writing to cancel it in such time as to afford Option Care and THE FINANCIAL INSTITUTION a reasonable opportunity to act upon it.

Vendor Name - PLEASE PRINT or TYPE Phone Number

Vendor **Remittance** Address - PLEASE PRINT or TYPE

Account Holder / Contact Person – PLEASE PRINT OR TYPE Signature

Address of Financial Institution Branch Name / Number

Address of Financial Institution (City, State, & Zip)

|  |  |
| --- | --- |
| Financial Institution Routing Number (9-digit number) |  Bank Account Number |

These numbers are located on the bottom of your check as follows:



Provide email address for payment notification (up to 3 addresses accepted)

|  |
| --- |
| **Agency Name:**  |
| **Tax ID:**  |
| **NPI:**  |
|  |
| **Email completed form, along with copy of voided check to: AgencyUpdateGroup@optioncare.com** |
|  |



***Clinical Specialties, an Option Care Health Company***

***ACH Authorization Form v10100114.xlsx v06/27/2023***