

Supp Name:
Supp Num:
Office use only



ELECTRONIC FUNDS TRANSFER AUTHORIZATION

Instructions complete all 4 sections: To initiate payment you must attach a VOIDED check (pre-printed/not handwritten) OR a signed letter from your Bank OR a signed Company Letter with all information needed and be a current/new vendor. For a savings account a letter must come from your Bank.

Section 1.
SET UP

Initiate Direct Deposit Change Deposit Information Terminate Direct Deposit

PLEASE PRINT (* INDICATES REQUIRED ITEMS)

Section 2.
COMPANY INFORMATION

*BUSINESS OR INDIVIDUAL NAME

*PAYMENT ADDRESS

CONTACT PERSON

*CITY, STATE, ZIP CODE

*E-MAIL ADDRESS FOR REMITTANCE ADVICE

*PHONE# (FOR QUESTIONS)

Section 3.
BANK INFORMATION

*BANK NAME

*ACCOUNT NUMBER

*BANK ROUTING/ABA #
(check with your banking institution)

*ACCOUNT TYPE: [] CHECKING [] SAVINGS

*BANK CONTACT

*BANK TELEPHONE NUMBER

Section 4.
AUTHORIZATION

I certify that the information above is true and correct, and that I, as a representative for the above named company, hereby authorize DaVita Inc. Accounts Payable to electronically deposit payments to the designated bank account. In case of inadvertent payments, the duplicate payment may be reversed. The financial institution is authorized to credit amounts to this account and reverse any duplicate credits. This authority remains in full force until DaVita Inc. Accounts Payable receives written notification requesting a change or cancellation.

*COMPANY AUTHORIZED NAME PRINTED

*AUTHORIZING SIGNATURE

DATE

RETURN TO DAVITA AP DEPARTMENT:

FAX

EMAIL

DaVita Kidney Care 866-452-1983
DaVita Medical Group 800-313-2380

AP.Vendorsetup@davita.com
DMGW9@davita.com

Phone 855-748-7717
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Setup Bank Verified on banking sites Bank Already Setup Setup Bank Account
 E-mailed Supp Acct is setup

Initials _____ Date _____