Attach Voided Check Here

Automated Clearing House (ACH) Debit Authorization Form

Lovelace Health Plan

Complete and send to Lovelace Health Plan Finance Department for Processing

Important Plan Information

Please Check all that apply: ( ) Group ( ) Member ( ) New ( ) Change

Group Name: _____
(Please Print)

Group # _____

Sub Group # _____

OR

Member Name: _____
(Please Print)

Subscriber ID# _____

Mailing Address: _____

Phone # _____

_____

_____

I hereby authorize Lovelace Health Plan or Lovelace Insurance Company, hereinafter called COMPANY, to initiate debit entries to the Checking or Savings account indicated below. The Financial Institution named below to debit the same to such account. **I am a signor on the account indicated below:**

Account Type: ( ) Checking or ( ) Savings

Bank Account Name _____
(Please Print)

Bank Transit Routing # _____
[Found on the bottom Left of your check (9 Digits)]

Mail to Finance Department:
Lovelace Health Plan
PO Box 27107
Albuquerque, NM 87125-9843
or
Fax: 505-727-1750

Checking Account #_____ **or Savings Account #** _____

Name of Financial Institution: _____

Address of Financial Institution: (City/State/Zip) _____

This authorization will remain in ***effect*** until COMPANY has received ***written notification*** of its termination in such time and in such manner as to afford the COMPANY a reasonable opportunity to act on it.

Name: _____
(Please Print)

Signature: _____ Date: _____

Note: Due to processing time it may take approximately 2 months for actual withdrawal to take place

Services funded in part under a contract with the State of New Mexico • A Medicare Advantage organization with a Medicare contract

Lovelace Health System, Inc. • Lovelace Insurance Company

Internal billing use only: Print Statement ID_____