PACE
BY INNOVATIVE INTEGRATED HEALTH

Electronic Payment Enrollment Form

Please complete this form in its entirety to ensure timely processing and make sure to attach a copy of a voided check or bank authorization letter for the account receiving the direct deposit.

Organization Information (required)			
Organization Name (same as Form W9 – Line 1):			
Billing Address	City	State	Zip
Taxpayer Identification Number (TIN)	Organization National Provider Identifier (NPI)		
Administrative Contact Information (required)			
Name (Last, First, MI)	Phone Number		
Email Address			
Financial Institution Information (required)			
Name on Bank Account			
Financial Institution Name	Financial Institution Phone Number		
Street Address	City	State	Zip
Routing Number	Account Number	Account Type ☐ Checking ☐ Savings	
Reason for Enrollment Submission (required)			
☐New Enrollment	☐ Enrollment Change	☐ Enrollment Cancellation	

Authorized Signature (required)

☐ By checking this box, I hereby authorize Innovative Integrated Health, Inc. (IIH) to initiate Automated Clearing House (ACH) or Electronic Funds Transfer (EFT) credit entries and, if necessary, debit entries and adjustments for any credit entries made in error to the above checking/savings account.

☐ By checking this box, I also authorize the aforementioned financial institution to credit and/or debit the same account.

☐ By checking this box, I certify that the information provided herein is true and accurate and that I am an authorized signer.

Authorized Signer Full Name	Authorized Signer Title
Authorized Signer Signature	Authorized Signer Signature Date

Please email this form and a copy of a voided check or bank authorization letter to finance@innovativeih.com.