State of Illinois
Department of Healthcare and Family Services
Bureau of Fiscal Operations

AUTHORIZATION FOR DIRECT DEBIT

Questions about direct debit transactions or to revoke authorization of payment
Call 1-877-828-2375

PLEASE PRINT CLEARLY
Completion of this form is optional

Mail completed form to:
Healthcare and Family Services
Bureau of Fiscal Operations
PO Box 19491 Springfield, IL 62794-9491

Applicant Information - Please complete the following section

Customer ID

Name

Account Holder - Please complete the following section

Name

Mailing Address

City, State and Zip

Financial Organization Information - Complete the following section or attach a voided check

Name of Financial Institution

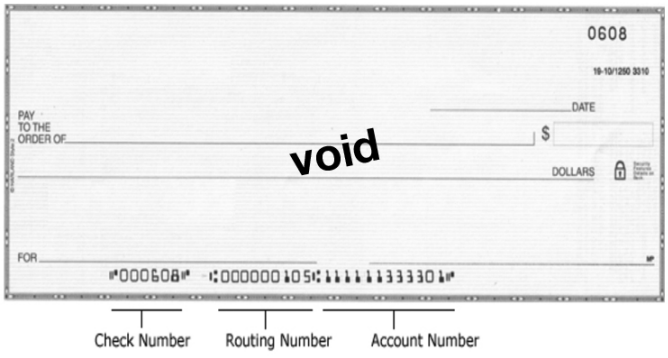
Bank Phone Number

Checking ☐ Savings ☐

Branch Address, City, State, Zip Code

Routing Number

Account Number



As a duly authorized signer on the account supplied above, I authorize the Bureau of Fiscal Operations to initiate debit entries to my account above on or about 4 business days prior to the due date, and to debit the account for the amount indicated on the invoice. If the account cannot be debited, I understand and accept full responsibility for ensuring that the invoice is paid. I acknowledge that the origination of ACH transactions to this account must comply with the provisions of U. S. Law.

This authorization is to remain in full force and effect until the Illinois Department of Healthcare and Family Services has received written notification of its termination in such time and in such manner as to afford the Illinois Department of Healthcare and Family Services and the financial institution above reasonable opportunity to act on it.

Signature of Payer

Date

Phone Number