HFS
Illinois Department of
Healthcare and Family Services

Community Mental Health Provider Directed Payment Form

Provider Information	
Provider Legal Name:	
Provider dba:	
Provider Tax ID:	
Contact Name for Directed Payments:	
Contact Phone for Directed Payments:	
Contact Email for Directed Payments:	
Preferred Payment Method (check the preferred method below and complete the corresponding fields)	
☐ **EFT** Bank Name: Account #: Routing #:	☐ **Check** Address: Pay to Name: Attention of: