



**Attachment B**

Arkansas Department of Health (ADH) – *BreastCare* Program  
**Authorization for Automatic Electronic Funds Deposit**

Provider Legal Business Name: \_\_\_\_\_ Provider #: \_\_\_\_\_

Doing Business As Name (DBA): \_\_\_\_\_

Provider Address: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

City, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Type of Authorization: Same  Change  New  *Please check appropriate box.*

**For verification purposes, please complete the following:**

Routing Transit #: \_\_\_\_\_ Bank Account #: \_\_\_\_\_

**PLEASE ATTACH A COPY OF A VOIDED CHECK TO VERIFY THESE NUMBERS.** The name on the voided check/deposit slip should match the name on the provider business name or DBA stated above

Name of Depository (Bank): \_\_\_\_\_

Depository Address: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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I hereby authorize the ADH, *BreastCare* to initiate credit entries to the account indicated above and the depository named above to *credit* the same to such account. I understand that I am responsible for the validity of information on this form.

I understand in endorsing this funds transfer that payment will be from Federal and State funds and that any falsification or concealment of a material fact may be prosecuted under Federal and State Laws.

ADH *BreastCare* will send the direct deposit to the Depository indicated above until notified by me that I wish to change the Depository receiving the direct deposit. If my Depository information changes, I agree to submit to *BreastCare* an updated Automatic Authorization Agreement.

**Authorized Official Name (Print):** \_\_\_\_\_

**Authorized Official Title:** \_\_\_\_\_

**Authorized Official Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please return this form to:**  
*BreastCare*  
ADH  
4815 WEST MARKHAM SLOT 11  
LITTLE ROCK AR 72205