healthplex

Provider Authorization Agreement
For Direct Deposit

Bank Information

Financial Institution | City | State

Transit/ABA # | Account # | ☐ Checking ☐ Savings

☐ Capitation ☐ Fee-for-Service ☐ Both

Authorization

Doctor/Practice Name

I / We hereby authorize Dentcare Delivery Systems, Inc., Healthplex, Inc. and/or its subsidiaries to initiate credit entries to my/our account indicated above at the depository bank named above, representing monthly capitation payment and/or Fee-for-Service payments. Debit charges to said account are not authorized, unless such charge represents a reversal of credit amounts erroneously posted by Dentcare Delivery Systems, Inc., Healthplex, Inc. and/or its subsidiaries.

Authorized Bank Account Signer Signature | Date

Authorized Bank Account Signer Name | Title

Site #(s) | TIN #/SS #

Contact Person's Name (please print)

Contact Phone # (including area code)

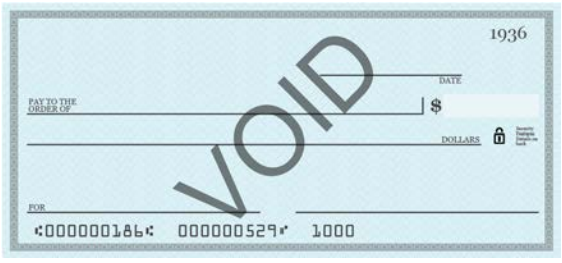
☐ **New**
Do not have
Direct Deposit

☐ **Add**
Add additional site
or TIN or location

☐ **Change**
Change in bank
and or Account #

☐ **Remove**
Does not want
Direct Deposit any longer

This authorization is to remain in full force and effect until Dentcare Delivery Systems, Inc., Healthplex, Inc. and/or its subsidiaries have received written notification from the undersigned of its termination in such time and in such manner as to afford the Companies and Depository bank a reasonable opportunity to act on it.



Please return completed form and copy of voided check to Accounting Dept. at accounting@healthplex.com Please allow 30-45 days for processing.

For Administrative use only

Processed Date | Initials

Notes

333 Earle Ovington Boulevard, Suite 300, Uniondale, NY 11553 | 516 745 0079 | accounting@healthplex.com