Heluna Health
The New PHFE

Please Fax Back to
Angels Child Care Food Program
562-908-0501 or Email to
Angelsfoodprogram@gmail.com

Direct Payment Authorization Agreement

Please use this form to request that your invoices/reimbursements be electronically deposited to the specified account. Failure to provide this information will delay the process of your request.

Banking Information *(Please complete ALL information)*

Enrollment Action: ☑ *(Please Check)* ☐ New ☐ Cancel ☐ Change

Amount of Deposit: ☑ Invoice/Reimbursement Amounts

*Bank Name*_____ *Branch* _____

Address _____ *City* _____

State _____ *Zip* _____ *Phone #* _____

*Bank Checking Account Number:*_____

*ABA:Routing Number*_____

Attach a voided check

Vendor/Payee Information *(Please complete ALL information)*

Vendor/Provider Name: _____

Address _____ *City* _____

State _____ *Zip* _____ *Phone #* _____

*Email address:*_____

Vendor/Payee Certification

I hereby authorize PHFE to process the direct payment instructions as indicated above. When signing this form, I am in agreement, that PHFE has the authorization to initiate debit entries and adjustments in order to correct any funds erroneously deposited into my account without any liability.

Authorized Signature _____ *Date* _____

Please attach to this section a copy of your VOIDED CHECK for a new or changed direct payment or a personal Direct Deposit Form from your bank that includes name, routing number and bank account number.