Vendor ACH/ Direct Deposit Authorization Form
OneSource Medical Diagnostics, LLC

1. Please Check One:

☐ NEW Direct Deposit ☐ CHANGE Direct Deposit ☐ CANCEL Direct Deposit

2. Vendor/Payee Information

Name:	
Address:	
Contact Person's Name (if other than payee)	
Telephone Number:	
Email Address:	

3. Financial Institution Information

Bank Name:			
Bank Address:			
Name on Bank Account:		Bank Account Number:	
Nine-Digit Bank Routing/Transit Number (ABA):			
Type of Account:	☐ Checking ☐ Savings		

4. Approvals/Authorizations

I certify that the information provided on this form is correct, and I hereby authorize OneSource Medical Diagnostics, LLC of Accounts Payable to electronically deposit payments to the bank account designated above. It is my responsibility to notify OneSource Medical Diagnostics, LLC, AP (accountspayable@onesmd.com, 877-674-8888 Ext. 3041) immediately if I believe there is a discrepancy between the amount deposited to my bank account and the amount of the invoice(s) paid. I understand that I must notify Expert MRI, AP in writing immediately of any changes in status or banking information. I understand that this authorization will remain in full force and effect until OneSource Medical Diagnostics, LLC, AP has received written notification requesting a change or cancellation and has had reasonable opportunity to act on it, which should take no longer than seven (7) to ten (10) business days.

Print Name:

Signature: Date:

Important Information Please return completed form via email:	accountspayable@onesmd.com		
For Office of Accounts Payable Use Only			
AP Reviewed and Approved:		**Date Stamp - Received:**	
Date:			