



### Company Payment Form – Electronic Check

*All fields must be completed for processing.*

*If we have any questions regarding your payment, a representative will contact you.*

Company Name (as shown on your statement):      Company Contact Name:      Company Phone Number:

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Company Contact Email Address:      Company Guarantor Number (9-digit number):

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**PAYMENT AMOUNT:**

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**PAYMENT BY ELECTRONIC CHECK:**

*A receipt will be mailed to the address on file after payment processing.*

Name of Banking Institution:

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Account Holder Name:

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Account Number:

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Confirm Account Number:

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Routing Transit Number:

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**WHERE DO YOU WANT YOUR PAYMENT APPLIED?**

<input checked="" type="checkbox"/> Oldest Charges**	<b>** If a box is not checked and special instructions are not provided, all payments will be applied to the oldest charges on the account.</b>
<input type="checkbox"/> Specific Date(s) of Service	Specific Instructions:
<input type="checkbox"/> Specific Patient Name	Specific Instructions:
<input type="checkbox"/> Statement Attached with Modifications	Specific Instructions:

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**ELECTRONIC SIGNATURE**

Name:

Date:

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**Email completed form and any additional information to:**  
[CompanyPayments@EssentiaHealth.org](mailto:CompanyPayments@EssentiaHealth.org)