



Authorization Agreement for Direct Deposit Provider Resources, Inc.

PLEASE ATTACH VOIDED CHECK TO THIS FORM

Name:		
Address:		
City:	State:	Phone:
Type of Account:		Checking or Savings
Transit Routing Number:		Account Number:

New Application Change of Account

I authorize and request Provider Resources, Inc. to directly deposit my check to my account named above. I further authorize and request that my bank accept any credit entries initiated by Provider Resources, Inc., and if overpayment occurs, Providers Resources, Inc. may make corrected entries to my account.

Signature of Applicant: _____ **Date:** _____