new mexico health connections

Automated Clearing House (ACH) Debit Authorization Form

PLEASE NOTE: We must receive this form by the 15th of the month prior to the draft date. For example, if you want us to begin drafting your account on February 1, we must receive the form by January 15. If we receive this form after the 15th of the month, we cannot begin drafting your account until the first of the following month. All contents of this form are required. Incomplete forms will not be processed and will be returned.

I have applied for an Individual/Family Plan and am completing this form to make payment for that policy.

Name: _____ Subscriber ID#: _____

Mailing Address: _____

Phone: _____ Email: _____

I hereby authorize New Mexico Health Connections (NMHC) to initiate debit entries to the checking or savings account indicated below and request the financial institution named below to debit the same to such account. This information will be kept for ongoing payments and the account listed will be drafted for the monthly premium amount. I am an authorized signor on the account indicated below:

Account Type: ☐ Checking ☐ Savings

Month to Begin Bank Draft: _____ (**Note**: Account will be drafted on the **first** business day of the month.)

Name of Financial Institution	Address of Financial Institution
Name of Account/Name on Account	
Financial Institution Transit Routing Number (9 digits – see diagram below)	Account Number (See diagram below)

FOR CHECKING ACCOUNTS ONLY:

If using a checking account, you ***must*** attach a voided check for financial institution and account information verification.

Your Name Check No.
Your Address
Your City, State, Zip

Pay to the order of:

Please attach an unsigned voided check here (if applicable)

In the amount of: Dollars

Financial Institution Name:

Memo:

|: 123456789 :| 00998765432

This is your bank's Transit Routing Number. *This is your Account Number.*

TO PAY USING YOUR CREDIT CARD, PLEASE COMPLETE THIS SECTION.

Cardholder Name: _____

Card Number: _____ _____ _____ _____ ☐ Visa ☐ Mastercard ☐ Discover

Expiration Date: _____ CVV (Card Verification Value; a three-digit code on the back of your card): _____

This authorization will remain in effect until New Mexico Health Connections has received written notification of its termination in such time and in such manner as to afford New Mexico Health Connections a reasonable opportunity to act on it.

Name (Please Print): _____

Signature: _____ Date: _____

Please mail this completed form to New Mexico Health Connections, Attn: Finance, P.O. Box 36719, Albuquerque, NM, 87176, or fax it to 1-888-966-0450.

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