

SOUTH SHORE HEALTH
EFT/ACH Authorization Form

Supplier Name:

Address:

A/R Contact Name:

A/R Contact Number:

Remittance Email:

**** This is the email SSH will send your payment remittance information ****

Bank Routing #

Account #

Account Type

Checking

Savings

Bank Name:

Signature:

Date:

**** ALL Suppliers/Contingent Workers are required to be Paid via EFT/ACH ****

***** Please contact the Accounts Payable Department at 781-624-8128 or 781-624-8121
if any information changes*****