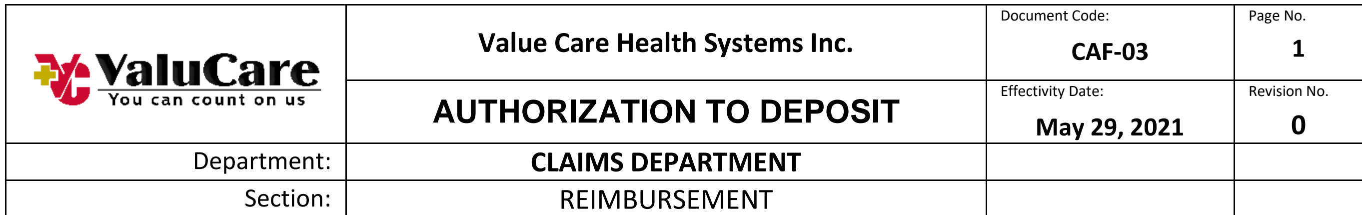

ValuCare You can count on us	Value Care Health Systems Inc.	Document Code: CAF-03	Page No. 1
	AUTHORIZATION TO DEPOSIT	Effectivity Date: **May 29, 2021**	Revision No. **0**
Department:	**CLAIMS DEPARTMENT**		
Section:	REIMBURSEMENT		

THE ACCOUNTING DEPARTMENT
Value Care Health Systems, Inc.

I hereby authorize the Accounting Department of Value Care Health Systems, Inc. to deposit to my Bank Account the approved sum for the following claim:

- ☐ **Reimbursement**
- ☐ **Financial Assistance**

My Bank Account details are as follows:

- Complete Name of Payee as enrolled in the bank___________________________________
- Bank Name and Branch____
- Bank Account Number of Payee____
- Address declared by Payee in the Bank____
- Email address____

I hereby hold Value Care Health Systems, Inc. or any of its officers, employees, and/or representatives from any legal liabilities relative to the herein mentioned consent which I have willingly and voluntarily given in connection with this claim.

Thank you,

Claimant_____________________________________
Signature over Printed Name

Date signed__________________________________