HOUSTON PHYSICIANS IPA
A NUTEX HEALTH COMPANY

# IPA VENDOR **SETUP** & AUTHORIZATION FORM

**Company Name:** _____ Tax ID/EIN: _____

**Doing Business As:** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip Code:** _____

**Phone Number:** _____ **Fax Number:** _____

**Remit to Address (if different from above):** _____

**City:** _____ **State:** _____ **Zip Code:** _____

**Accounts Payable:**

**Select preferred option:**

☐ **Email EOB to Accounts Payable Email**

☐ **Mail EOB to Address indicated on W9**

**Contact:** _____

**Phone Number:** _____ **Email Address:** _____

**Banking Information:** ☐ Checking ☐ Savings Bank Name: _____

**Bank** Address: _____ **Bank Code or ABA Number:** _____

_____ **Account Number:** _____

**Description of Services Provided:** _____

SUPPLIER AUTHORIZATION:

By signing this document, you have agreed to authorize NUTEX HEALTH and/or ITS subsidiaries to deposit payments electronically into the account indicated above. This authorizes the financial institution holding the account to POS all such entries. You agree that the ACH transactions authorized herein shall comply with all applicable U.S. Law.

Print Name: _____ Signature: _____ Date: _____

**Please complete the attached form, signed, and include a blank voided check (photocopy is acceptable) or letter from your banking institution.**

## REMAINDER TO BE COMPLETED BY NUTEX STAFF

**The Company website was checked for reasonableness? _____ (Y/N)**

**Employee Requesting New Vendor:** _____

**Employee Reviewing this Form:** _____

**Director of Accounting (or equivalent) Approval:** _____

**CFO or COO Approval (for Related Party or Friend working at Nutex):** _____

***ALL REQUESTED INFORMATION MUST BE OBTAINED.***

**If emailed EOBs are requested, it will come from secured MSO email of TVu@MSOSoCal.Com. The secured emails will delete within 30 days. Any additional EOBs are subjected to $5 fee.**