AGENCY INFORMATION

Please list information on your agency as a whole and return to the address listed below with the necessary documentation.

1) Agency/Group name: _____

2) Private Practice? ❑Yes ❑No

3) Main office address: _____

_____ County: _____

4) Main telephone # of practice: _____

5) Main fax # of practice: _____

6) E-mail (if applicable): _____

7) How do you prefer to receive referrals? (Fax or Email) _____

8) Do you have any clinicians on staff who are trained to do CISD (Critical Incident Stress Defusing/Debriefing) and would be able to assist us in an emergency situation?
   ❑Yes ❑No

9) Do you have any clinicians on staff who are able to do telephonic or online counseling?
   Telephonic: ❑Yes_____ ❑No
   Online: ❑Yes_____ ❑No

10) Please list contact information for your agency if we have any questions or concerns.

Name/Title _____

Phone _____ Extension _____ Fax _____

11) Please list any additional offices your practice maintains. (Use a separate sheet if necessary.)

Address: _____

Phone (if different): _____ Fax (if different): _____

Address: _____

Phone (if different): _____ Fax (if different): _____

12) If you have more than one location, referrals should be directed to:

❑ Main office number ❑ Individual office where client will be see

13) Please list all insurances accepted by your practice:

_____

_____

14) How do you prefer to receive payment: ❑Direct Deposit (See next page) ❑ Check

Mazzitti & Sullivan EAP Services is a subsidiary of Pyramid Healthcare, Inc. Our preferred method of payments to our vendors is electronically depositing to a bank account.

Please complete the information below and return using one of the methods below:

Email to: info@mseap.com
Fax to: 717-561-1125
Mail to: 479 Port View Drive, Suite C30, Harrisburg, PA 17111

Vendor ACH / Direct Deposit Authorization Form

Pyramid Healthcare, Inc. and Subsidiaries, Office of Accounts Payable

1. Please Check One:	
☐ NEW Direct Deposit	☐ CHANGE Direct Deposit

2. Vendor / Payee Information:
Name:
Address:
Contact Person's Name (if other than payee):
Telephone Number:
Email Address:

3. Financial Institution Information:	
Bank Name:	
Bank Address:	
Name on Bank Account:	
Bank Account Number:	
Nine-Digit Bank Routing / Transit Number (ABA):	
Type of Account:	
☐ Checking	☐ Savings

4. Approvals / Authorizations – I certify that the information provided on this form is correct, and I hereby authorize Pyramid Healthcare, Inc. and its Subsidiaries to electronically deposit payments to the bank account designated above. It is my responsibility to notify Pyramid Healthcare, Inc. immediately if I believe there is a discrepancy between the amount deposited to my bank account and the amount of the invoice(s) paid. I understand that I must notify Pyramid Healthcare, Inc. in writing immediately of any changes in status or banking information. I understand that this authorization will remain in full force and effect until Pyramid Healthcare, Inc. has received written notification requesting a change or cancellation and has had reasonable opportunity to act on it, which should take no longer than seven (7) to ten (10) business days.

Print Name: _____ Signature: _____ Date: _____