

Department of Health and Human Services

Program Support Center

INDIVIDUAL/BUSINESS INDICATOR

I B

CASE/DEBT/CLAIM NO.

BUSINESS NAME

SSN/TIN

FIRST NAME

LAST NAME

PAYMENT AMOUNT

PAYMENT TYPE (Pick One)

ACH Credit Card

ACH INFORMATION

CREDIT CARD INFORMATION

ABA/RTN

ACCOUNT NUMBER

CARD EXPIRATION DATE

BANK ACCOUNT NUMBER

CARDS ACCEPTED (Choose which card you are using)

POINT OF CONTACT

VISA MC DISCOVER AMERICAN EXPRESS

FIRST NAME

LAST NAME

TELEPHONE

EXTENSION

Submit Data