DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Medicare Hearings and Appeals

PAYMENT INFORMATION REPORT

PERSONAL INFORMATION

Name

Address

City	State	ZIP Code

Home Phone	Work Phone
( )	( )

Social Security Number *(or other Taxpayer Identification Number)*	E-Mail

BANKING INFORMATION

(Complete this entire section or attach a voided check from your account.)

Name of Financial Institution

Address of Financial Institution

City	State	ZIP Code

Routing Transit Number *(9 positions)*	Account Title

Account Number	Type of Account *(please check one)*
	☐ Checking ☐ Savings

TRAVELER'S CERTIFICATION

Signature	Date

PRIVACY ACT STATEMENT

The legal authority for the collection of information on this form is authorized by the Social Security Act (section 1155 of Title XI and sections 1852(g)(5), 1860D-4(h)(1), 1869(h)(I), and 1876 of Title XVIII). The Social Security Number will be used to verify the identity of the traveler. Submission of the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the ability to process your claim for reimbursement. The requested information concerns your financial institution, your account at that institution, and personal information which needs to be provided to Department of Health and Human Services to process your claim for reimbursement. This confidential information will be used by the U.S. Department of the Treasury to transmit payment data by electronic means through the Automated Clearing House to your financial institution.