DIRECT DEPOSIT AUTHORIZATION AGREEMENT

I hereby authorize Prospect Medical to deposit any amounts owed me by initiating credit entries to my checking account at the financial institution (hereinafter "Bank") indicated below. Further, I authorize the Bank to accept and to credit any credit entries initiated by Prospect Medical to my checking account. I authorize Prospect Medical to debit my checking account for an amount not to exceed the original amount of an erroneous credit.

Bank Institution (attach a voided check)

Bank Name: _____

Address: _____

City, State, Zip : _____

This authorization is to remain in full force and effect until Prospect Medical or Bank has received written notice from me of its termination in such time and in such manner as to afford Prospect Medical and Bank a reasonable opportunity to act on it.

Provider Name (please print): _____

Provider Signature: _____

Federal Tax ID Number: _____

Phone Number: _____

Date: _____

Fax OR Email this completed form and a copy of the voided check to:

Prospect Medical

Attention: ACH-EFT Payment Processing Department

Fax #: (714) 560-7618

OR

Email Address: ach-eft@prospectmedical.com (attach in PDF format)

Important Note: Avoid delays in processing by remembering to include a voided check to proceed with direct deposit.