

**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)
\$0.00 ACH Credit Card

ABA/RTN ACH INFORMATION CREDIT CARD INFORMATION
ACCOUNT NUMBER CARD EXPIRATION DATE

BANK ACCOUNT NUMBER CARDS ACCEPTED (Choose which card you are using)
 VISA MC DISCOVER AMERICAN EXPRESS

POINT OF CONTACT TELEPHONE EXTENSION
FIRST NAME LAST NAME