Essentia Health

Company Payment Form – Credit/Debit Card

All fields must be completed for processing.
If we have any questions regarding your payment, a representative will contact you.

Company Name *(as shown on your statement)*:	**Company Contact Name:**	**Company Phone Number:**

Company Contact Email Address:	**Company Guarantor Number (9-digit number):**

PAYMENT AMOUNT:

$

PAYMENT BY CREDIT/DEBIT CARD:

A receipt will be mailed to the address on file after payment processing.

Card Holder Name:

Credit / Debit Card Number:

Card Expiration Date:

3-Digit Security Code:

Billing Address:	**Billing City/State:**	**Billing Zip Code:**

WHERE DO YOU WANT YOUR PAYMENT APPLIED?

☐ Oldest Charges**	**** If a box is not checked and special instructions are not provided, all payments will be applied to the oldest charges on the account.**
☐ Specific Date(s) of Service	**Specific Instructions:**
☐ Specific Patient Name	**Specific Instructions:**
☐ Statement Attached with Modifications	**Specific Instructions:**

ELECTRONIC SIGNATURE

Name:	**Date:**

Email completed form and any additional information to: CompanyPayments@EssentiaHealth.org