PAYMENT INFORMATION FORM
ACH VENDOR PAYMENT SYSTEM

This form is used for the ACH payments with an addendum record that carries payment-related information. Recipients of these payments should bring this information to the attention of their financial institution when presenting this form for completion.

PAPERWORK REDUCTION ACT STATEMENT

The information being collected on this form is required under the provision of 31 U.S.C. 3322 and 31 CFR 210. This information will be used by the Treasury Department to transmit payment data by electronic means to vendor's financial institution. Failure to provide the requested information may delay or prevent the receipt of payments through the Automated Clearinghouse Payment System.

MEDICAL PROVIDER INFORMATION			
OWCP Provider ID			
Name			
Address			
Contact Person Name		Telephone Number	

AGENCY INFORMATION	
Name: U.S. Department of Labor-Office of Workers' Compensation Program	
Address: Provider Enrollment	
P.O. Box 34690, San Antonio, TX 78265	
Contact Person Name:	Telephone Number:

FINANCIAL INSTITUTION INFORMATION					
Name					
Street Address					
City		State	Select	Zip Code	
ACH Coordinator Name		Telephone Number			
Nine-Digit Routing Transit Number					
Depositor Account Title					
Depositor Account Number					
Type of Account	☐ Checking	☐ Savings			
Signature and Title of Representative		Telephone Number			

SF Form 3881

Department of the Treasury Financial Management Service