AdventHealth UNIVERSITY

Third Party Billing Form – Distance

Financial Services
671 Winyah Drive
Orlando, FL 32803
Phone: 407-303-5782; Fax: 407-303-7680
Email: Kimberly.cherella@ahu.edu

(Use this form only if your employer/organization is paying for part or all of your tuition)

STUDENT INFORMATION – Please print or type.

Name: ID: Date:

Address:

City/State/Zip: E-Mail Address:

Daytime Phone/Extension: Social Security Number: - -

Program ☐ Online Bachelor of Science in Nursing ☐ Online Bachelor of Science in Radiologic Sciences
Semester ☐ Fall ☐ Spring ☐ Summer ☐ Online Bachelor of Science in Diagnostic Medical Sonography

Course #	Course Name	Course Dates	Cost
		Matriculation Fee	**$**
		Total Cost of Textbooks	**$**
		Total Cost	**$**
Amount authorized to be paid by employer - Pay this amount to AdventHealth University			**$**

By completing and signing this form, you, as an authorized agent of your company, enter into an agreement with the above-named student to serve as a third party billing designee, and will remit payment in the amount listed above Adventist University of Health Sciences in accordance with your company's individual tuition remission policy.

Authorized Company Representative (printed) **Authorized Company Representative (signature)**

Title and Telephone Number **Employer**

Employer Billing Address **City/State/Zip**

Notice to student: You are ultimately responsible for making sure that your bill is paid, in full, and on time. If your employer fails to provide timely payment of any outstanding debt, your credit card will be charged for the amount owed. Please provide information below.

Credit Card Authorization – **Please circle one**: MC VISA DISCOVER AMEX

Credit Card #: Expiration Date:
Name on Card: Signature:

☐ **Florida Prepaid:** ☐ **Restricted** (invoice per credit hour) or ☐ **Unrestricted** (invoice full amount). Must provide copy of card with this form.

☐ **Educational Subsidy:** Name, Address and Phone Number of Academy, Conference or College Subsidy _____

Employee Name: _____

☐ **Vocational Rehabilitation:** Contact Name_____

☐ **Other 3rd Party Billing Information Not Listed Above:** Organization Name, Address, and Phone Number_____

Contact Name: _____