OPTUMRx® Electronic funds transfer enrollment form

Submission information

Reason for submission (check the one that applies)

New enrollment ☐ Change enrollment ☐ Cancel enrollment ☐ Submission date _____

Type of financial document that will be provided for verification purposes. Void Check ☐ Bank Letter ☐

Name of person submitting enrollment _____Title_____

Provider information according to NCPDP site

REQUIRED Provider Legal Name _____

REQUIRED Doing business as name (DBA) _____

Physical Address:

Street _____ City _____

State_____ Zip Code _____

Mailing Address:

Street _____ City _____

State_____ Zip Code _____

Provider identifiers information

REQUIRED Provider Federal Tax Identification Number (TIN) _____

Provider type (check the one that applies)

Medical ☐ Dental ☐ Behavioral Health ☐ Vision ☐ Pharmacy ☐

Provider contact information

Primary contact

Provider contact name _____Title (optional) _____

Telephone number _____Extension _____

Email address _____Fax number _____

Secondary contact

Provider contact name _____Title (optional) _____

Telephone number _____Extension _____

Email address _____Fax number _____

Electronic funds transfer enrollment form continued

Pharmacy, PSAO or Chain Information

Provider name_____

NCPDP Number _____ PSAO/Chain Code _____

Authorization Agreement for Automatic Deposits (ACH Credits)

(I) _____hereby authorize UnitedHeathcare, hereinafter, called COMPANY, to initiate credit entries and, if necessary, debit entries and adjustment for any credit entries in error to my (our) checking/savings account(s) indicated below and the bank named below, hereinafter called BANK, to credit and/or debit the same account.

Financial Institution Information

Financial institution Name _____

Street _____ City _____

State/province _____ZIP code/postal _____Telephone number _____Extension_____

Type of account (check one) Checking ☐ Savings ☐ Fax number _____

Bank Routing number _____ Bank Account number _____

Below area MUST be filled by hand

MUST BE HANDWRITTEN INITIALS AND SIGNATURE BELOW (no electronic initials or check marks)

_____I acknowledge that before EFT payment enrollment can be completed, I may be required to complete enrollment to receive electronic remittance advices.

_____I acknowledge that the pharmacy I am enrolling is not a member of a PSAO. (For Pharmacies use only)

_____I represent that I have the authority to enroll the pharmacy identified below.

The organization identified above authorizes OptumRx, through its designated financial institution, to make electronic payments to the checking account at the depository financial institution (depository) named above for services performed under the Prescription Drug Services Agreement ("Agreement") between the organization identified above and OptumRx and its affiliates. Such payments shall be made through the regional automated clearinghouse (ACH) associations, subject to the operating rules of the National Automated Clearinghouse Association. This authorization is ancillary to the Agreement, and shall not be deemed to alter or amend any terms of the Agreement. This authorization is to remain in full force and effect until it is revoked. Revocation will be effective within a reasonable period following receipt of written notice by OptumRx, which will be no later than thirty (30) days after receipt of written notice. Notice of revocation must be provided to OptumRx at the address set forth above. OptumRx may cease providing any or all of the EFT services upon notice to the Primary Contact named above. Revocation will not apply to transactions initiated before the effective date of such revocation. The pharmacy identified above certifies that the above information is true and accurate in all respects and will promptly notify OptumRx at the address listed above of any changes to the information on this form.

Authorized HANDWRITTEN signature required

Signature _____ **Date** _____

Note:Void check or bank letter attached MUST match the information on the EFT form. Bank letter CANNOT be more than 90 days old. If the information does not match the EFT form, additional information must be provided to validate relationship.

No alterations are allowed to originally submitted forms. Any needed corrections require a new form to be completed.

Once completed print to sign and initials by hand.

Print Form

Send the form to OptumRx: E-mail: PharmacyOperationsEFTsetup@optum.com

Reset Form