OPTUM Rx®

Electronic funds transfer enrollment form

Submission information

Reason for submission (check the one that applies)

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

A voided check or bank verification letter must be included with this form. ☐ Voided check ☐ Bank letter

Name of person submitting enrollment _____ Title _____

Provider information

Provider name _____

Doing business as name (DBA) _____

Street _____ City _____

State/province _____ ZIP code/postal code _____ Country code (optional) _____

Provider identifiers information

Provider Federal Tax Identification Number (TIN) _____ or National Provider Identifier (NPI) _____

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 _____

Retail pharmacy information (optional except for pharmacies)

Pharmacy name _____ chain number _____

NCPDP provider ID number _____

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 code _____ Telephone number _____ Extension _____

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

Provider's account number _____

Account number linkage to provider identifier* _____

Provider Federal Tax Identification Number (TIN) _____ National Provider Identifier (NPI) _____

To ensure you are eligible for this program, please initial below to acknowledge

_____ I acknowledge that, once enrolled, the pharmacy I am enrolling below will be required to receive electronic delivery of 835 remittance advices.

_____ I acknowledge that the pharmacy I am enrolling is not a member of a PSAO.

_____ 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 signature required

Signature _____ Date _____

Send completed forms to:

OptumRx
P.O. Box 6104
Cypress, CA 90630-6104
Fax number:800-732-7601

*Provider preference for grouping (bulking) claim payments — must match preference for v5010X12 835 remittance advice