Tracking ID #XXXXX

Electronic Funds Transfer Enrollment Form

Provider Information:

Provider Name

Doing Business As Name (DBA)

Provider Address:

- 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: (Circle the one that applies)

- Medical
- Dental
- Behavorial Health
- Vision
- Pharmacy

Provider Contact Information:

Primary Contact:

- Provider Contact Name
- Title (Optional)
- Telephone Number
- Telephone Number Extension
- Email Address
- Fax Number

Secondary Contact:

- Provider Contact Name
- Title (Optional)
- Telephone Number
- 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

Financial Institution Address:

- Street
- City
- State/Province
- Zip Code/Postal Code

Financial Institution:

- Telephone Number
- Telephone Number Extension

Financial Institution Routing Number

Type of Account at Financial Institution: (Circle the one that applies)

- Checking
- Savings

Provider's Account Number with Financial Institution

Account Number Linkage to Provider Identifier ***

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

Submission Information:

Reason for Submission: (Circle the one that applies) New Enrollment Change Enrollment Cancel Enrollment	
Include with Enrollment Submission: A Voided Check or Bank Verification Letter must be included with this form. Voided Check Bank Letter	
Written Name of Person Submitting Enrollment (Paper Only)	
Printed Name of Person Submitting Enrollment	
Printed Title of Person Submitting Enrollment	
Submission Date (CCYYMMDD)	

Send completed forms to:

Business Unit Name:	**OptumRx**
Business Unit Mailing Address:	**P. O. Box 6104**
City, State and Zip:	**Cypress, CA 90630-6104**
Business Unit Fax Number:	**800-732-7601**

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

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: