OPTUMRx®

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) _____

Physical Address:

Street _____ City _____

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

Mailing Address:

Street _____ City _____

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

Provider identifiers information

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 code _____Telephone number_____Extension_____

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

Bank Routing number _____ Bank Account number _____

To ensure you are eligible for this program, Please **INITIAL** below to acknowledge.

MUST BE HANDWRITTEN INITIALS AND SIGNATURE BELOW

_____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 OptumRxand 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 theAgreement, 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 writtennotice by OptumRx, which will be no later than thirty (30) days after receipt of written notice. Notice of revocation must beprovided to OptumRx at the address set forth above. OptumRx may cease providing any or all of the EFT services uponnotice to the Primary Contact named above. Revocation will not apply to transactions initiated before the effective date ofsuch revocation. The pharmacy identified above certifies that the above information is true and accurate in all respectsand will promptly notify OptumRx at the address listed above of any changes to the information on this form.

Authorized HANDWRITTEN signature required

Signature_____Date _____

Send completed forms to:

OptumRx:

E-mail: PharmacyOperationsEFTsetup@optum.com