meridianRx
1 Campus Martius, Suite 750
Detroit, MI 48226

313-324-3800
TTY: 711
www.meridianrx.com

MeridianRx Electronic Funds Transfer (EFT) Enrollment Form

Note: Pharmacy is not eligible for EFT if you are receiving your payments through a Pharmacy Services Administrative Organization (PSAO) set up with central pay. The central pay PSAO is eligible to receive EFT. If you are an affiliate of a PSAO utilizing central pay and would like to change your payment to EFT, you will need to contact your PSAO directly.

PART I: REASON FOR SUBMISSION

☐ New EFT Authorization ☐ Revision to Existing Enrollment (e.g. account or bank changes)
☐ Cancel EFT ☐ Enroll in Electronic Remittance Advice (ERA) to Receive 835 Transmissions

PART II: PHARMACY/ORGANIZATION INFORMATION

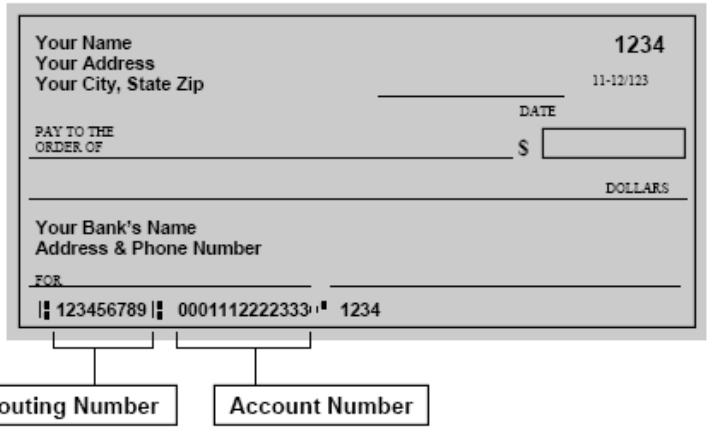
Tax ID:	Chain Code/Payment Center ID/NCPDP:	
Organization Name:		
Address:		
City:	State:	Zip Code:

PART III: PHARMACY/ORGANIZATION CONTACT

Name:	Email Address:	
Title:	Phone Number: ( )	Fax Number: ( )

PART IV: DESIGNATION OF DEPOSITORY

Bank Name:	Account Name:	
Bank Address:		
City:	State:	Zip Code:
Bank Contact Name:	Bank Contact Phone Number: ( )	
Bank Account Number:	Routing Transit Number:	
Account Type: ☐ Checking Account	☐ Savings Account	



Please attach a copy of a voided check to the Enrollment Form. If the ACH routing number on your check differs from the ACH routing number identified by your financial institution, please provide a written letter of explanation from your financial institution. In these cases, the ACH number identified in the letter is the number that should be provided in the account information section above.

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PART V: ELECTRONIC REMITTANCE ADVICE INFORMATION		
If the pharmacy would like to receive electronic remittance, please fill out the contact information below only. MeridianRx will contact this person to set up electronic file receipt. Pharmacy will still receive paper remittance unless requested otherwise.		
☐ Direct Pharmacy Contact		
Contact Name:	Contact Phone Number: ( )	
Contact Email:		
ERA Delivery Options – **select one** ☐ Secure Email ☐ Deliver to Pharmacy SFTP server (please complete information below): FTP Host Address:_____ Login ID: _____ Password: _____ Directory: _____ PGP Name: _____ ☐Retrieve from MeridianRx SFTP		
☐ Third Party for Account Reconciliation Contact		
Name of Third Party:		
Third Party Contact Name:	Third Party Contact Phone: ( )	Email:

Authorization:
I represent that I have the authority to enroll the Pharmacy identified on this form for EFT and/or ERA.

The organization identified above authorizes MeridianRx, through its designated financial institution, to make electronic payments to the checking/savings account at the depository financial institution (depository) named above for services performed under the Participating Pharmacy Agreement ("Agreement") between the organization identified above and MeridianRx. Such payments shall be made through the regional automated clearing house (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. Notice of revocation must be provided to MeridianRx at the address set forth below. MeridianRx may cease providing any or all of the EFT services upon notice to the Primary Contact named above. Revocation will not apply to the transaction 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 MeridianRx in writing via certified mail with return receipt or via overnight service by a national courier at the address below of any changes to the information on this form. If the Pharmacy utilizes any Third Party payment reconciliation organizations; the Pharmacy must provide evidence of participation and notify MeridianRx if that relationship dissolves to adjust delivery of remittance advices. Notifications from the Pharmacy required under this Authorization must be sent to MeridianRx in writing via certified mail with return receipt or via overnight service by a national courier.

Authorized Signature Required

Printed Name:	Signature:
Title:	Date:

After completing the enrollment form, please return completed forms and attachments by fax to 313- 202-1255, scan and email to pharmacyservices@meridianrx.com or mail to:

MeridianRx
Attn: Network Management,
1 Campus Martius, Suite 750
Detroit, MI 48226

Please feel free to contact Network Management with any questions at 866-984-6462.

ENROLLMENTS ARE PROCESSED WITHIN TWO (2) WEEKS OF RECEIPT. PLEASE KEEP A COPY OF THE COMPLETED AND SIGNED ENROLLMENT FORM FOR YOUR RECORDS.