Electronic Funds Transfer and Remittance Advice Authorization Agreement

Prescryptive provides payment for all claims electronically via ACH. Please complete this form and attach a Bank Letter to receive electronic ACH payments and electronic remittance advice for approved claims.

Send completed form and **Bank Letter** to **pharmacyrelations@prescryptive.com**

Select One: ☐ **New** ☐ **Change** ☐ **Cancel**

Provider Information:
Provider Name:
Street Address:
Federal Tax ID Number (TIN) or Employer Identification Number (EIN):
National Provider Identifier (NPI):
Contact Name:
Telephone Number:
Email Address:
Pharmacy Name:
NCPDP/Provider ID:
Payment Center ID:

Financial Institution Information:
Financial Institution Name:
Street Address:
Telephone Number:

Account Information:		
Account Type:		
Routing Number:		
Account Number:		
Account Number Linkage to Provider Identifier (select one):	☐ Tax Identification Number (TIN)	☐ NPI

835 Electronic Remittance Advice (ERA):

By supplying this information, you are requesting Prescryptive Health, Inc. to provide an electronic remittance advice(HIPAA 835 format) via secure FTP (SFTP). **Signature page follows on page 2**.

Account Information:
835 Processor Name:
Contact Name:
Email Address:
Phone Number:

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Electronic Transmission of Standard Remittance Advice PDF:

If you are not requesting 835 ERA, Prescryptive supports transmission of a PDF image of standard remittance advice via secure e-mail in PDF format. If you select this format by providing the email address below, you warrant that access and retrieval of the .pdf remittance advice will be compliant with all HIPAA and other applicable laws and performed by authorized personnel only.

Provider Secure Email Address:

Authorization:

By signing this form, I hereby authorize Prescryptive Health, Inc. to transmit all HIPAA required data in the 835 ERA which includes claims information, payment information, bank account information, provided by me and currently on file to the processor identified above. This authorization will remain in effect until changed or cancelled in writing. I attest that all information provided in this authorization agreement is true, accurate, and complete. I represent that I am an authorized representative of the Provider identified above designated to enter into legal and binding contracts on their behalf. Further, I understand that remittance advice contain Protected Health Information (PHI) and have taken the necessary steps to maintain the confidentiality of PHI in accordance with applicable law.

_____

Authorized Signature

_____

Name

_____

Title

_____

Date

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