835 PHARMACY PAYMENT SET UP/CHANGE FORM

Please FAX completed request to: (480) 314-6027

Pharmacy Name:

Action Requested: Effective Date:

Chain Code/NCPDP #: Federal Tax ID #:

Select all that apply: ☐ Caremark ☐ Aetna

Pharmacy

Pharmacy Name: Attention:

Street Address:

City: State: Zip:

Phone : Fax: Pharmacy Email Address:

Pharmacy Technical Contact: Phone: Fax:

Pharmacy Technical Email Address:

Vendor

Vendor Name: Attention:

Street Address:

City: State: Zip:

Phone : Fax: Vendor Email Address:

Vendor Technical Contact: Phone:

Fax: Vendor Technical Email Address:

Pharmacy Approval: Title:

Submitted Date: