Caremark Medicare Part D
EFT Set-Up Request

This form is used to establish electronic funds transfer payment for Caremark Medicare Part D claims. Please complete all sections in RED on your computer, then print, sign and fax as indicated below.

EFT Request Type:

☐ New EFT Set-Up ☐ Change to Existing EFT Set-Up ☐ Cancel EFT

Pharmacy Type:

☐ Independent ☐ Chain

NCPDP# : ______ **NPI # :** ______ **Chain Code# :** ______

Pharmacy / Chain Name: ______

Address (street, city, state, zip): ______

Phone: ______ **Fax:** ______

Contact Name: ______

Contact Email Address: ______

Pharmacy/ Chain Email Address: ______

EFT Banking Information:

Bank Account # : ______

ABA Routing Number: ______

Account Name: ______ **Account Type:** ______

Bank Name: ______

Bank Address/ City/ St/ Zip: ______

**** REQUIRED: Submit a copy of a voided, blank check or deposit slip as page 2 of this EFT request****

By signing below, you authorize Caremark to make electronic credit entries, and any necessary adjustments involving these entries, in the indicated account at the financial institution designated above, and you authorize the Bank to accept such entries and make any necessary adjustments. This authorization will remain in effect until written notice of EFT Change/Cancellation is delivered to Caremark and Caremark has had reasonable opportunity to process the change/cancellation. In no event shall such change/cancellation be effective as to entries processed prior to receipt of such notice.

Please print, sign below and fax to: Caremark Med D EFT / Fax # : 480-614-7443

Signature of Requestor: ______________________ **Date:** ______________________

Printed Name of Requestor: ______________________ **Title:** ______________________

Please allow 30 days for establishment of or changes to your Caremark EFT set-up.
Payment terms will be set by Caremark, in accordance with applicable law and any Plan Sponsor requirements.