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Caremark EFT Set-Up/Change Request

Please complete all sections in RED on your computer, then print, sign email / fax form as indicated below and include a check copy or bank letter. Form must be signed by the Pharmacy owner, a Corporate Officer, or by an Authorized agent(ie., Officers, President or VP). Authorized agents shall be only those persons assigned the authority to enter into contracts on behalf of the organization as indicated in the entity's corporate resolutions. The Caremark EFT Setup/Change request must be submitted from the enrolled fax number or email address.

CHANGES: As outlined in the CVS Caremark Provider Manual, EFT Bank Account changes will result in a $50 fee. Fee will be collected by CVS Caremark on future Remittance Advice. New EFT setups will be performed at no charge.

EFT Request Type:

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

Pharmacy Type:

☐ Independent ☐ Chain **Tax ID:**

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

Pharmacy / Chain Name:

Street Address:

City: **State:**

Phone: **Fax:**

Contact Name:

Contact Email:

Pharmacy/Chain Email Address:

EFT BANKING INFORMATION

Routing Number:

Account Number:

Account Name: **Account Type:** Checking

Bank Name:

**** Required: Submit a copy of a voided blank check or bank letter 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 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 the entries processed prior to receipt of such notice.

Please print, sign below and fax to: Caremark EFT Request / Fax #: 480-614-7443 OR Email : PharmacyEFTRequests@caremark.com

Authorized Signature: **Date:**

Authorized Printed Name: **Title:**

Please allow 30 days for establishment of, or change to CVS Caremark EFT request. Payment terms will be set by CVS Caremark, in accordance with applicable law and any Plan Sponsor requirements. (v8a)

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