



Instructions for completing the Electronic Funds Transfer Authorization Form

Rx Options, Inc. is happy to provide our participating pharmacies with the opportunity to receive payment electronically via ACH for the prescriptions they dispense.

In order to take advantage of this payment option you must also be signed up to receive an 835 Electronic Remittance Advice. Please contact us at pharmacyaccountingissues@envisionrx.com if you need more information.

Please fill out the enclosed Authorization Form completely and return it to us using one of these methods:

By Mail: Rx Options, Inc. Attn: Pharmacy Payables
8957 Canyon Falls Blvd
Twinsburg, OH 44087

By Fax: 330-486-4801, Attn: Pharmacy Payables

By e-mail: pharmacyaccountingissues@envisionrx.com

You may also complete this form online at:

<https://www.envisionrx.com/PrescribersAndProviders/Pharmacies#ElectronicPaymentAndRemittance>

If you have any questions about these instructions or are unsure of how to complete this Authorization Form you may e-mail your questions to pharmacyaccountingissues@envisionrx.com or call us toll free at 1-800-361-4542 and ask for pharmacy payables.

Provider Name This is the complete legal name of your institution or corporate entity.

Provider Address The complete street address where this institution or corporate entity is located.

Provider Identifiers Enter your full 9 digit Federal Tax ID number and your full 10 digit NPI. If you do not have an NPI enter "n/a."

Provider Contact Name Enter the name of your contact person who handles EFT issues.

Telephone Number Enter the telephone number of the contact person who handles EFT issues.

Email Address Enter the email address of the contact person who handles EFT issues.

Pharmacy Name This is the complete name by which your pharmacy is known.

NCPDP Provider ID Enter your NCPDP number.

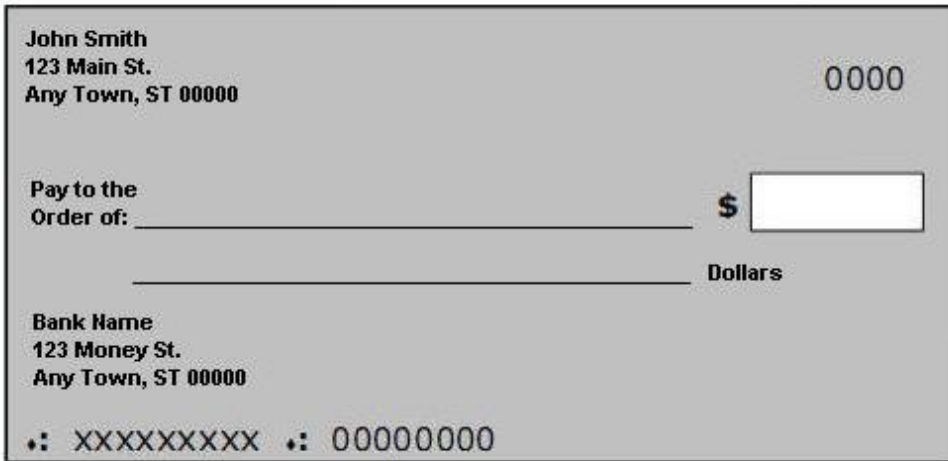
Financial Institution Name This is the official name of the financial institution where your deposit account is held.

Financial Institution Address The complete street address of the financial institution where your deposit account is held.

Financial Institution Telephone Number Enter the telephone number for a contact person at the financial institution where your deposit account is held.

Financial Institution Routing Number This is the 9 digit identifier of the financial institution where your deposit account is held. It can be found at the bottom of your check between the colons. (see example below)

Provider's Account Number with Financial Institution This is the checking account number to which EFT payments are to be deposited. (see example below.)



This is the 9 digit Financial Institution Routing Number.

This is the account number.

Account Number Linkage to Provider Identifier Enter either your TIN or NPI. If you receive an Electronic Remittance Advice this must match your preference for aggregating the remittance data.

Reason for Submission Select the reason you are submitting this form by marking the box with an "X."

Include with Submission Select the documentation you will supply by marking the box with an "X" and include this with your Authorization Form.

Voided Check: A voided check is attached to provide confirmation of Identification / Account Numbers.

Bank Letter: A letter on bank letterhead that formally certifies the account owners routing and account numbers.

Authorized Signature Submission Date This form must be signed and dated by an individual authorized by the provider to initiate, modify or terminate an enrollment. By signing this form you are instructing Rx Options, Inc. to transmit payment for prescriptions filled by the pharmacy identified on the form via ACH transaction to the deposit checking account identified on the form.

Late/Missing EFT and ERA Resolution Procedures

According to **CAQH Committee on Operating Rules for Information Exchange (CORE) Phase III CORE 370 EFT & ERA Reassociation (CCD+/835) Rule version 3.0.0**, late or missing is defined as a maximum elapsed time of four business days following the receipt of either the Healthcare EFT Standards or v5010 X12 835.

If you think your EFT or ERA is late/missing please contact us by email at pharmacyaccountingissues@envisionrx.com or toll free by phone at 1-800-361-4542 and ask for pharmacy payables. Please include the date, dollar amount and reassociation information for the EFT/ERA in your possession so we can provide you with the file you are missing.



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Rx Options, Inc. is happy to provide our participating pharmacies with the opportunity to receive payment electronically via ACH for the prescriptions they dispense.

Please fill out this Authorization Form completely, including your business checking account information, and return it to us using one of these methods:

By mail: Rx Options, Inc. Attn: Pharmacy Payables
8957 Canyon Falls Blvd
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By Fax: 330-486-4801, Attn: Pharmacy Payables

By e-mail: pharmacyaccountingissues@envisionrx.com

You may also complete this form online at:

<https://www.envisionrx.com/PrescribersAndProviders/Pharmacies#ElectronicPaymentAndRemittance>

Provider Name _____

Provider Address _____

Street _____

State/ ZIP Code/

City _____ Province _____ Postal Code _____

Provider Identifiers

Provider Federal Tax Identification
Number (TIN) or Employer Identification
Number (EIN) _____

National Provider Identifier (NPI) _____

Provider Contact Name _____

Telephone Number _____

Email Address _____

Pharmacy Name _____

Payment Center ID _____

NCPDP/Provider ID Number _____

Financial Institution Name _____
Financial Institution Address _____
Street _____
State/ ZIP Code/ _____
City _____ Province _____ Postal Code _____

Financial Institution Telephone Number _____

Financial Institution Routing Number _____

Type of Account at Financial Institution **checking**
Provider's Account Number _____
with Financial Institution _____

Account Number Linkage to Provider Identifier
Provider Tax Identification Number (TIN) _____
National Provider Identifier (NPI) _____

Reason for Submission select one
New Enrollment
Change Enrollment
Cancel Enrollment

Include with Submission include one
Voided Check X
Bank Letter

Authorized Signature _____

Submission Date _____

By signing this form you allow Rx Options, Inc. to transmit funds to the above bank account via ACH for the pharmacy identified herein.
In order to initiate electronic funds transfer you must also be signed up to receive an 835 electronic remittance advice. Please contact pharmacyaccountingissues@envisionrx.com if you need more information.



Instructions for completing the Electronic Remittance Advice Authorization Form

Rx Options, Inc. is happy to provide our participating pharmacies with the opportunity to receive remittance details electronically in HIPAA 835 format.

In order to take advantage of this option you must also be signed up to receive payments via Electronic Funds Transfer. Please contact us at pharmacyaccountingissues@envisionrx.com if you need more information.

Please fill out the enclosed Authorization Form completely and return it to us using one of these methods:

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- Provider Name** This is the complete legal name of your institution or corporate entity.
- Provider Address** The complete street address where this institution or corporate entity is located.
- Provider Identifiers** Enter your full 9 digit Federal Tax ID number and your full 10 digit NPI. If you do not have an NPI enter "n/a."
- Provider Contact Name** Enter the name of your contact person who handles ERA issues.
- Telephone Number** Enter the telephone number of the contact person who handles ERA issues.
- Email Address** Enter the email address of the contact person who handles ERA issues.
- Pharmacy Name** This is the complete name by which your pharmacy is known.
- Payment Center ID** Enter the assigned payment center identifier associated with your institution or corporate entity (if applicable).
- NCPDP Provider ID** Enter your NCPDP number.

Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)	Enter either your TIN or NPI. If you receive payment via Electronic Funds Transfer this must match your preference as listed for the Account Number Linkage.
Vendor Name	If you use a third party vendor to receive and reconcile your ERA enter their name here. Otherwise enter "n/a."
Vendor Contact Name	Enter the name of a contact person in the vendor office who handles ERA issues. If you do not use a third party vendor enter "n/a."
Telephone Number	Enter the telephone number of the vendor contact person who handles ERA issues. If you do not use a third party vendor enter "n/a."
Email Address	Enter the email address of the vendor contact person who handles ERA issues. If you do not use a third party vendor enter "n/a."
Reason for Submission	Select the reason you are submitting this form by marking the box with an "X."
Authorized Signature Submission Date	This form must be signed and dated by an individual authorized by the provider to initiate, modify or terminate an enrollment. By signing this form you are instructing Rx Options, Inc. to transmit remittance details for prescriptions filled by the pharmacy identified on the form via HIPAA 835 electronic format.

Late/Missing EFT and ERA Resolution Procedures

According to **CAQH Committee on Operating Rules for Information Exchange (CORE) Phase III CORE 370 EFT & ERA Reassociation (CCD+/835) Rule version 3.0.0**, late or missing is defined as a maximum elapsed time of four business days following the receipt of either the Healthcare EFT Standards or v5010 X12 835.

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Provider Name _____

Provider Address _____

Street _____

State/ ZIP Code/

City _____ Province _____ Postal Code _____

Provider Identifiers

Provider Federal Tax Identification
Number (TIN) or Employer Identification
Number (EIN) _____

National Provider Identifier (NPI) _____

Provider Contact Name _____

Telephone Number _____

Email Address _____

Pharmacy Name _____

Payment Center ID _____

NCPDP/Provider ID Number _____

Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)

Provider Tax Identification Number (TIN) _____

National Provider Identifier (NPI) _____

Method of Retrieval: The provider will be given access to an assigned folder on our secure ftp

website. Vendor Name _____

Vendor Contact Name _____

Telephone Number _____

Email Address _____

Reason for Submission select one

- New Enrollment
- Change Enrollment
- Cancel Enrollment

Authorized Signature _____

Submission Date _____

By signing this form you are requesting that Rx Options, Inc. provide you with an electronic remittance advice (HIPAA 835 format) instead of a paper remittance advice. You are also acknowledging that you have proper computer capabilities in order to access/download this electronic remittance advice from our secure ftp website. Rx Options also uses PGP encryption as a secondary step in protecting PHI. You will need to supply us with your PGP Public Key during the set up process. In order to initiate this process you must also be signed up to receive payments via Electronic Funds Transfer. Please contact us at pharmacyaccountingissues@envisionrx.com if you need more information.