ACH REQUEST FORM

This form is used for enrollment in the Automated Clearing House (ACH) process for payments. Please complete the following information pertaining to the payee's (pharmacy or chain) financial institution. This request should be completed and signed by the pharmacy authorized representative.

RETURN COMPLETED FORM BY EMAIL OR FAX TO:

MC-Rx - Finance Department (ePayments)

Email: financeservices@mc-rx.com

Fax: 1-787-653-2850

Payee / Pharmacy Information

Payee Name: _____

Payee ID (NCPDP ID/Chain Code): _____

Pharmacy Contact Name: _____

Title: _____

Signature: _____

Date: _____

Phone Number: _____

Email Address: _____

Financial Institution Information

Financial Institution's Name: _____

Bank Account Number: _____

Bank Routing Transit Number: _____

** Include voided check here **