

Pharmacy Electronic Funds Transfer (EFT) Payment Request Form

Thank you for your interest in receiving remittances via EFT. Please email or fax this completed form to:

Email: eftsupport@envolvehealth.com
 Fax: (866) 912-6293

Please check one:		Chain <input type="checkbox"/>		Independent <input type="checkbox"/>	
Pharmacy Name					
Pharmacy NCPDP # or Chain Code					
Pharmacy Address					
City		St		Zip Code	
Contact Person					
Contact Phone					
Contact Fax					
Contact Email					
Bank Account Name					
Account Number				Checking <input type="checkbox"/>	Savings <input type="checkbox"/>
Routing Number					
Bank Name					
Bank City		St		Zip Code	