EXPRESS SCRIPTS®

Provider Electronic Remittance Authorization Form

This form must be completed by Provider to receive electronic remittance data directly via Internet/FTP, or to authorize a third party reconciler to retrieve the Provider's ASC X12N 835 electronic remittance advice files on behalf of the Provider.

Authorization

Express Scripts Inc. ("ESI") is hereby authorized to release 835 electronic remittance files for Provider to the Third Party Reconciler if one is identified below.

Provider acknowledges that the information contained in an 835 electronic remittance file contains confidential patient health information (PHI) and other confidential information, as defined in the *Network Provider Manual.* The party signing this document certifies that he/she is authorized to provide this information to ESI.

This agreement will remain in effect until a written notice for cancellation is received and processed by ESI.

Third Party Reconciler Information (if applicable)

(Leave blank if pharmacy is receiving their files directly)

Vendor Name: _____

Contact Person: _____ Title/Position: _____

Vendor Address: _____

_____

_____

Vendor Telephone Number: _____ Vendor Fax Number: _____ E-Mail: _____

Provider Information

Provider is a*:* NCPDP/NPI _____ NCPDP/Chain _____

Provider Name: _____

Contact Person and Title/Position: _____

Authorized Name: _____

Authorized Signature: _____

Date Signed: _____

Provider Address (mailing address; for chain, the headquarter address):

_____

_____

_____

Provider telephone number: _____ Provider e-mail address: _____