EXPRESS SCRIPTS®

PROVIDER ELECTRONIC PAYMENT AND REMITTANCE ENROLLMENT FORM

To enroll in electronic payment and electronic remittance advice, complete and sign this form in two places. A copy of voided check or bank letter is required to complete this form. NOTE: Incomplete forms will be returned. EFT form of payment is not available for Workers Compensation.

Mail original signed form to: **Express Scripts, 8640 Evans Ave, St Louis Mo 63134**

or Email to Remittance@express-scripts.com or Fax to 877-892-2692

☐ **TRICARE** ☐ **Commercial** ☐ **Med D**

PROVIDER INFORMATION		
Provider Name:		
Street Address:		
City:	**State:**	**Zip:**

PROVIDER IDENTIFIERS INFORMATION

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

National Provider Identifier (NPI)

NCPDP

Chain Code

PROVIDER CONTACT INFORMATION		
Provider Contact Name:		
Phone:	**Fax:**	**E-Mail:**

FINANCIAL INSTITUTION INFORMATION:
Financial Institution Name:
Financial Institution Routing Number (populate below):

Checking Account at Financial Institution:

Provider's Financial Institution Account Number:

Account Number Linkage to Provider Identifier:		
		Provider Tax Identification Number (EIN)
Reason for Submission:		
		New Enrollment
		Change Enrollment
		Cancel Enrollment

AUTHORIZED SIGNATURE:
Electronic Signature of Person Submitting Enrollment:
Printed Title of Person Submitting Enrollment:

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