

## 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](mailto: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)																					
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National Provider Identifier (NPI)	NCPDP																				
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Chain Code																					
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PROVIDER CONTACT INFORMATION		
Provider Contact Name:		
Phone:	Fax:	E-Mail:

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

