EFT

Electronic Funds Transfer Authorization Form

Elixir is happy to provide our participating pharmacies with the opportunity to receive payment electronically via ACH for the prescriptions they dispense.

Please use the **Fill & Sign option** in Adobe to fill out the enclosed Authorization Form completely and return it to us by **e-mail**:
pharmacypayables@elixirsolutions.com

Please do not FAX or MAIL the forms.

Provider Name _____

Provider Address

Street _____

City _____ State/Province _____ ZIP Code/Postal Code _____

Provider Contact Name _____

Telephone Number _____

Email Address _____

Pharmacy or DBA Name _____

NCPDP/Provider ID Number _____

Payment Center ID (if applicable) _____

National Provider Identifier (NPI) _____

Banking Details

BankName _____ State _____

Bank Account Number _____

Bank Routing Number _____

Reason for Submission select one

- New Enrollment ☐
- Change Enrollment ☐
- Cancel Enrollment ☐

Include with Submission include one

- Voided Check ☐
- Bank Letter ☐

Authorized Signature _____

Submission Date _____

By signing this form, you allow Elixir to transmit funds to the above bank account via ACH for the pharmacy identified herein.

NOTE: To initiate electronic funds, transfer you must also be signed up to receive an 835 electronic remittance advice. Please contact **pharmacypayables@elixirsolutions.com** if you need more information.

ERA
Electronic Remittance Advice Authorization Form

Elixir is happy to provide our participating pharmacies with the opportunity to receive remittance details electronically in HIPPA 835 format.

Please use the **Fill & Sign option** in Adobe to fill out the enclosed Authorization Form completely and return it to us by **e-mail**:
pharmacypayables@elixirsolutions.com

Please do not FAX or MAIL the forms.

Provider Name _____

Provider Address

Street _____

City _____ State/ Province _____ ZIP Code/ Postal Code _____

Provider Contact Name _____

Telephone Number _____

Email Address _____

Pharmacy or DBA Name _____

NCPDP/Provider ID Number _____

Payment Center ID (if applicable) _____

National Provider Identifier (NPI) _____

Method of Retrieval

If you use a third-party vendor to receive and reconcile your claims enter their name here.
The provider will be given access to an assigned folder on our secure FTP website.
For Example: Net Rx, Prism/Inmar, Freedom (FDS)

OR

If you wish to reconcile the claims yourself enter Self Reconciliation or PGP Key in this space, please supply your **PUBLIC** PGP ENCRYPTION KEY (.asc file), a voided check or bank letter, and the required forms (four pages) all together to **pharmacypayables@elixirsolutions.com**

Reconciliation Company Name or Self Reconciliation _____

Contact Name _____

Telephone Number _____

Email Address _____

Reason for Submission select one

New Enrollment ☐
Change Enrollment ☐
Cancel Enrollment ☐

Authorized Signature _____

Submission Date _____

By signing this form, you are requesting that Elixir provide you with an electronic remittance advice (HIPPA 835 format) instead of a paper remittance advice.

You are also acknowledging that you have proper computer capabilities to access/download this electronic remittance advice from our secure ftp website.

Elixir also uses PGP encryption as a secondary step in protecting PHI. You will need to supply us with your PGP Public Key during the set-up process.

NOTE: To initiate this process, you must also be signed up to receive payments via Electronic Funds Transfer. Please contact us at **pharmacypayables@elixirsolutions.com** if you need more information.