Electronic Funds Transfer (EFT) Authorization Form
Rituxan Immunology and ACTEMRA Co-pay Card Program

P.O Box 2106, Morristown, NJ 07962

Phone: (855) 722-6729
Fax: (800) 334-3030
www.RACopay.com

Before you can use this form to request Electronic Funds Transfer (EFT) reimbursement services, your practice must register to use the Rituxan Immunology and ACTEMRA Co-pay Card Program and have access to the provider portal. If you have not yet completed this onetime registration, please call Rituxan Immunology and ACTEMRA Co-pay Card Program at (855) RA-COPAY (855-722-6729).

This form must be completed in its entirety.

Health Care Professional/Facility Information		
Primary physician name:	Practice name *(if applicable)*:	
Street address:		
City:	State:	ZIP:
Phone number:		
Primary contact's name (office financial manager):	Primary contact's title:	
Primary contact's phone number:	Primary contact's fax number:	
Additional physicians' National Provider Identifier (NPI):		

Instructions for Requesting EFT Services

Your practice must register for this EFT service at www.RACopay.com and provide the required information, including the practice's bank account information. To begin this process, you must first complete the form and then fax this form back to (800) 334-3030. The total approved amount for each co-pay assistance claim submitted to the Rituxan Immunology and ACTEMRA Co-pay Card Program will be electronically transferred to the registered bank account. The Rituxan Immunology and ACTEMRA Co-pay Card Program will notify the practice and the patient each time a claim has been paid. The account can be changed at any time by logging on to www.RACopay.com with your practice's account information. When you log on to www.RACopay.com, you will be required to provide your account number, routing number, account type (business checking, business savings, other [personal account, etc]), financial institution name, financial institution address and a scanned copy of a voided check or specification sheet.

Authorization

I hereby attest I am the account holder or authorized designee of the account holder and authorize The Macaluso Group (TMG), on behalf of the Rituxan Immunology and ACTEMRA Co-pay Card Program, to collect and use these funds for the purpose of making a credit or transferring a payment to said account at the above-named facility. Furthermore, authorization is granted to correct inadvertent duplicate or overpayment transactions. It is acknowledged that neither Genentech USA, TMG nor their respective affiliates shall be responsible for any delay or loss of funds due to incorrect information submitted by me, any of the authorized representatives on the account or my financial institution. This authorization shall remain effective until notification is provided to TMG (at least ten [10] business days) via an updated Electronic Funds Transfer Authorization Form.

Authorized signature:	
Printed name:	Date:

Your office will be contacted at the phone number provided above within 48 hours of receipt of this fax form.

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