

Dear Valued Supplier:

Attached is our ACH application. Please take a moment to review the following instructions.

1. Please complete the attached forms. An electronic signature will not be accepted.
2. Please provide a voided check copy or bank verification letter. ACH will not be established without this documentation.
3. In order to establish ACH payments, CVS Health requires additional days on vendor terms so that CVS Health remains mail float neutral.

Please return completed forms to:

Email: LiveOnPay.Resolution@CVSCaremark.com

**OR**

CVS Health

Attn: 2210 (LOP)

200 Highland Corporate Dr

Cumberland, RI 02864

**TAPE A COPY OF YOUR VOIDED CHECK HERE**





**ACH Payment Add or Account Change Request**

The following information is required for CVS Health to initiate ACH payments or change existing ACH payment bank routing-account information.

CVS Health Supplier Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CVS Health Vendor # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Federal Tax ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Payment Terms: Current \_\_\_\_\_\_\_\_\_\_\_\_\_\_ New \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***CHECK REMITTANCES CORRESPONDENCE INFORMATION***

Old Remittance Address: Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Remit Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address Line 1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address Line 1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address Line 2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address Line 2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zip Code \_\_\_\_\_\_\_\_\_\_\_ Telephone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***ACH ELECTRONIC PAYMENTS***

Old Account/Bank Information: New Account/Bank Information:

Bank Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bank Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bank Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bank Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address Line 2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address Line 2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State \_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_

Routing/ABA # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Routing/ABA # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Account # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Account # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Payee Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Payee Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Payee Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Payee Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Requester’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Requester’s Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Requester’s Telephone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Requester’s E-mail Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CVS Health Business Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Verbal Confirmation Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**International ACH Transaction Rules**

In connection with certain processing requirements for electronic supplier payments that are sent to a financial institution outside of the United States, CVS Health Corporation needs to know whether our payments to you are being forwarded from a United States financial institution to a financial institution in another country.

The particular rules are referred to as “International ACH Transaction (IAT) rules” and are pursuant to requirements of the Office of Foreign Assets Control.

In order for CVS Health Corporation to comply with the IAT rules and the applicable United States laws, you are requested to complete the “IAT Payee Affirmation Statement” below and return it with the ACH application. Failure to complete and promptly return the Affirmation Statement will make you ineligible to receive payments electronically.

**IAT Payee Affirmation Statement**

I represent that I have all requisite power, authority and capacity to execute this IAT Payee Affirmation Statement on behalf of my business. In addition, I acknowledge that electronic payments to the designated account for my business must comply with the provisions of United States law, as well as the requirements of the Office of Foreign Assets Control (OFAC).

**Please check one of the following**:

\_\_\_\_\_ I affirm that, regarding electronic payments that CVS Health Corporation may remit to the financial institution for credit to the account that I have designated, the entire payment amount **is not** subject to being transferred to a foreign bank account.

\_\_\_\_\_ I affirm that, regarding electronic payments that CVS Health
Corporation may remit to the financial institution for credit to the account that I have designated, the entire payment amount **is** subject to being transferred to a foreign bank account. I understand that any payments that may be remitted to my business in the future may be labeled with “IAT” as the standard entry class. I also understand that CVS Health Corporation may elect to remit future payments to my business in any manner that it deems necessary to comply with the IAT rules.

***Please note that by signing this IAT Payee Affirmation Statement, you agree to notify CVS Health Corporation promptly in the event that the selection above is no longer correct.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name and Title