AUTHORIZATION AGREEMENT FOR AUTOMATIC DEPOSITS (ACH CREDITS)
EXHIBIT D

Pharmacy Information	
Pharmacy/Organization Name:	
NCPDP # or Chain Code(s):	Tax ID No.:

Please attach a separate page if you have multiple NCPDP #s (Independent Pharmacy) or multiple Chain Codes (Chain Pharmacy).

I (we) hereby authorize Gateway Pharmacy Networks, LLC, hereinafter called **COMPANY**, to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error, to my (our) Checking ___ Savings ___ account (must select one) indicated below and the depository named below, hereinafter called **DEPOSITORY**, to credit and/or debit the same to such account.

Bank/Depository Name:			
Address:	City:	State:	Zip:
Bank Account No.:	Bank Routing No.:		

This authority is to remain in full force and effect until **COMPANY** has received written notification from me (us) of its termination in such time and in such manner as to afford **COMPANY** and **DEPOSITORY** a commercially reasonable opportunity to act on it.

Please make sure that all information is accurate and complete. Failure to do so will delay activation.

Contact Information			
Pharmacy/Organization Authorized Representative:			
Title of Authorized Representative:	Signature of Authorized Representative:		
Address:	City:	State:	Zip:
Phone No.:	Fax No.:		
E-mail:	Date:		

□ Only enroll in ACH payment

□ Enroll in 835 files (electronic remittance). Please include contact information for authorized 835 representative:

835 Contact Information	
Pharmacy/Organization Authorized Representative:	
Title of Authorized Representative:	Phone No.:
E-mail:	Date:

FAX TO 937.755.1431