# Electronic Funds Transfer (EFT) Authorization Form
# OCREVUS Co-pay Program

**100 Passaic Avenue, Suite 245, Fairfield, NJ 07004**
**Phone: (844) 672-6729**
**Fax: (855) 672-6729**
**www.OCREVUSCopay.com**

Before you can use this form to request EFT services, your practice must register to use the OCREVUS Co-pay Program and have access to the Tool Center at www.OCREVUSCopay.com. If you have not yet completed this onetime registration, please call the OCREVUS Co-pay Program at (844) 672-6729.

**This form must be completed in its entirety.**

| **Health Care Professional/Facility Information** | | |
|---|---|---|
| Primary physician name: | Practice name: | |
| Billing street address: | | |
| City: | State: | ZIP: |
| Billing phone number: | | |
| Primary contact's name (office financial manager): | Primary contact's title: | |
| Primary contact's phone number: | Primary contact's fax number: | |
| Additional physician names: | | |

## Instructions for Requesting EFT Services

**Your practice must register for this EFT service at www.OCREVUSCopay.com and provide the required information, including the practice's bank account information.** To begin this process, you must first fill out and fax back this form to (855) 672-6729. The total approved amount for each co-pay assistance claim submitted to the OCREVUS Co-pay Program will be electronically transferred to the registered bank account. The OCREVUS Co-pay Program will notify the practice and the patient each time the card has been funded. The account can be changed at any time by logging on to www.OCREVUSCopay.com with your practice's account information. When you log on to www.OCREVUSCopay.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 OCREVUS Co-pay 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.**



Genentech
*A Member of the Roche Group*