PharmaTrack
Your Trusted Partner

ACH Enrollment Form

Banking Information

Depository/Bank name: _____

Address: _____

City/State/Zip: _____

Bank Contact:_____

Phone Number:_____

Transit routing/ABA Number:_____

Checking Account Number:_____

Business Information

Business Name: _____

Address: _____

City/State/Zip: _____

Business Contact: _____

Phone Number: _____

_____ _____

Authorized Signature Date

_____ _____

Authorized Individual's Name Title

Please attach a void copy of the check Complete Form and return by Fax or mail to:

PharmaTrack LLC

PO BOX 600914 JACKSONVILLE FL 32260

4445 Hwy Ga 40 East STE 304 SAINT MARYS GA 31558

Phone 1-912-289-7001

Fax 1-912-289-7031

office@pharmatrackusa.com