Internal Use
Account Name:
Account Number:

INDEPENDENT PHARMACY DISTRIBUTOR

"A Wholesaler Independents Can Trust"

ACH Bill Payment Enrollment Form

(ACH-Automatic Option)

Account Name (as printed on your Bank Statement)

Address (as printed on your Bank Statement) City State Zip Code

Financial Institution Information	
Financial Institutional Name:	Branch:
Financial Institutional Address:	City:
State:	Zip Code:
9 Digit ABA Routing/Transit Number:	Account Number:
Checking:	Savings:

Please enclose a Voided Check with the Form
ACH Payment Transaction Will Be Processed On the Invoice Due Date.

The undersigned owner or authorized officer of the entity reflected below hereby authorize Independent Pharmacy Distributor LLC to debit the financial institution named above and to debit the same to such account. I (We) achknowledge that the origination of ACH transactions to my (our) account must comply with U.S. law. This authorization shall continue until written notification is received by IPD to cancel. I (We) can stop payment of any entry by notifying my (our) financial institution three (3) days before my (our) account is charged.

Print Name and title

Signature (Must be authorized account signer) Date

Submit completed form to IPD Accounting Department: ar@ipdpharma.com