CALIFORNIA ELECTRONIC FUND TRANSFER (EFT) REQUEST

Please enroll my company in the Medi-Cal rebate EFT payment option.

Labeler Name	
Labeler Address	
Contact Person	
Email Address	
Phone Number	
Fax Number	

Labelers Name	Labeler Number	Labelers Bank ID Number (10 digits)

Labeler Authorization Signature: _____
Date: _____

DHCS use only

Accounting Dept Received by: _____ Date: _____

Drug Rebate Dept Approval: _____ Date: _____

Account Created: _____ Date: _____

Email completed form to: mcdracct@dhcs.ca.gov