REQUEST FOR PROVISION OF SERVICES

Acct. # _____

Facility: _____

House Hold: _____

Resident Name: _____ Date of Birth: _____

Social Security #: _____ Medicare #: _____

Resident Home Phone: _____

Physician's Name: _____ Phone# _____

Physician's Address: _____

Primary Prescription Insurance: _____

Cardholder Name: _____

Relationship to Cardholder: ☐ Self ☐ Spouse ☐ Child ☐ Other

ID# _____ Rx Group # _____ Rx BIN # _____

Rx PCN # _____ Insurance Company's Phone Number: _____

Please select one of the following statement options:

☐ Send statements to (billing address):

Mr./Mrs./Ms.: _____ Relationship to Resident: _____

Street: _____

City: _____ State: _____ Zip: _____

☐ Send statements via Email: _____

Preferred Contact Method:

☐ Phone: _____

☐ Text: _____ * By selecting this option, I agree to receive text messages. Message and data rates from my carrier may apply.

Please check below:

☐ I authorize Connecticut Pharmacy to keep my signature on file and to charge my Visa/MasterCard/American Express/Discover account for monthly medication statement charges. I understand that this form is valid through the expiration date of the card unless I cancel the authorization through written notice to Connecticut Pharmacy.

☐Visa ☐MasterCard ☐American Express ☐Discover Card

Credit Card #					–					–					–				

Expiration Date: Month _____ Year _____ CV _____

Cardholder (print) (as it appears on card): _____

Cardholder Signature: _____

Cardholder's Address: _____

City: _____ ST: _____ Zip: _____

Please read and sign: I understand that by signing this agreement, I indicate my wish to purchase medications and health care products/services from Connecticut Pharmacy. I (Resident) agree to be personally responsible for the charges of any medications and health care products/services provided by Connecticut Pharmacy to Resident. The responsible party is not personally responsible for charges unless the responsible party has power of attorney for estate, or has taken charge of managing any personal funds. The responsible party agrees to assist Connecticut Pharmacy to obtain payment if the Resident is unable.

_____ _____ _____

Date of Agreement Client Signature

_____ _____

Guarantor Signature Relationship

To ensure proper billing, please enclose copies (front & back) of Insurance cards

AL and RCH only: HIPAA Received: Y/N Date: _____ Resident initials _____