Daly Drug Long Term Care
Drug Authorization /New Resident Form

Before prescriptions can be sent, ENTIRE FORM must be filled out, signed and dated.

HIPPA-PrivacyPolicy Signed? (pg 3) _____ (yes/no) **Date of Admission_____**

Facility Name:_____Address_____

Name of Resident: _____**Phone**_____
Drug Allergies_____
Birthdate_____ **Sex: Male / Female Social Security#**_____

Medicare Number:_____**SeniorCare/Medicaid#**_____
Inclusa _____ Western Wis Cares_____Care Wis_____

Medicare Part D Info:
Name of Insurance_____**Bin#**_____**PCN#**_____
Group #_____**ID #**_____

Other Insurance:
Name_____**Phone#** _____
Bin#_____**PCN#**_____
ID# _____**Group#** _____
Please fax a copy of the Insurance Cards and this form to Daly Drug Long Term Care at **715-423-5523**

Other Information:

**If we are repacking medications brought in from an outside source (ex. VA/Mail order company) there will be a charge of $5.00 per drug per dose. These medications will have to be at the Pharmacy 2 WEEKS PRIOR to Facilities medication cycle. You will be charged our cash price if medication is not here in a timely matter. It is the responsibility of the Patient/Family/Guarantor to order these medications.

Does the Residents Prescription Insurance Plan pay for more than a 30-day supply?_____(yes or no). The facility requires us to dispense a 31 day supply with months that have 31 days in them; however, many insurance companies won't allow more than 30 days to be dispensed. You will be required to either contact your insurance company to get an override or pay cash for those pills not covered. Please also double check that your insurance will **not charge you 2 copays for 31 days. You will be charged that amount.

**For Residents that are moving into a facility with Electronic Mars (billed under EMARS) there will be a fee of $10.00/month.

**There is a $30 fee per month for blister packs for Residents in their Own Home.

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Will the bills get mailed to the Resident? _____ If No, then fill out who the billing will go to.

Billing Name: _____ **Phone**:_____

Relationship to Resident:_____

Billing Address: _____

_____

(Please complete the entire address: City, State, Zip code)

The Guarantor or Resident agrees to pay Daly Drug Long Term Care **monthly** for all items ordered by the Facility and/or Doctor. If the account is more than **30 days past due**, Daly Drug LTC reserves the right to cancel any further service to the Facility until the account is current. Unfortunately, per state law, **we cannot accept for return/credit any prescription accepted and signed for by the Facility**. It is the responsibility of the Facility to **fax us the discontinued order written by the Physician** the same day they are notified otherwise you may be charged for the item. **Also make sure to contact the Pharmacy with any changes in status of the resident to avoid additional charges.** By signing and dating you also agree to all the above fee's (in Other Info section).

****Guarantor/Resident Signature and Date**:_____

For your convenience, we can use a credit card for payment. If you wish to use this service, please fill out and sign.
I authorize Daly Drug LTC to charge the monthly billing to the following **credit card**:
Type of Card _____ **Card Number** _____**Exp Date**_____
Security Code_____**Zip Code of the Billing Address on the Card**_____
Name on the Card _____

Cardholders Signature: _____ Date: _____

Emergency Contact Info: (If Resident is receiving the bills themselves)

Name:_____**Phone:**_____
Relationship to Resident:_____

Address:_____

_____

(Please complete the entire address: City, State, Zip code)