Lincoln
PHARMACY

821 South 38th Street Tacoma, WA 98418
253-473-1155p 253-473-1158f
www.LincolnRx.com

COMMUNITY INTAKE FORM

Resident Name: ______________________________ Date of Birth: ______________
Social Security Number: ________________ Medicare Number ________________
Primary Insurance: ________________ Customer Service Number: ______________
ID# ______________ Bin# __________ Grp#__________ PCN# __________
Secondary Insurance: ________________ Customer Service Number: ______________
ID# ______________ Bin# __________ Grp#__________ PCN# __________
(Copy of front and back of ALL insurance cards is required)
Primary Care Physician:________________ Phone: __________ Fax: __________
Diagnosis: ______________________ Allergies: ______________________
______________________ ______________________
______________________ ______________________

Responsible Party: ______________________ Relation: ______________
Billing Address: ____
(Please list the address you wish the statement to be mailed to)
Phone: ______________________ Alternate Phone: ______________
Bill my credit card: (□ one time □ monthly) Type of card: □ Visa □ MC □ American Express □ Discover
Credit Card Number: ______________ Expiration Date: ________ Security Code Number: ______

Lincoln Pharmacy works in conjunction with ______________________, to ensure the management of medications, orders, refills and supplies are completed in a safe and orderly fashion. As the Responsible party I understand that Lincoln Pharmacy is obligated to abide by any requests put forth in order to maintain health and safety of the resident. At which point the regular process would be communicated to the community's staff. I understand that I am financially responsible to Lincoln Pharmacy for all charges incurred for the named resident. If the resident has Medicaid, all non-covered OTC and supplies will be billed to the resident, unless prohibited by regulations. I understand that I am responsible for payment of any medications or other charges for the resident not covered by third party insurance while he/she resides in the community. I understand that Lincoln Pharmacy will attempt to bill insurance for all medications, equipment and supplies provided to the named resident. I agree to assume responsibility for paying all charges incurred.

Statement balances will be mailed at month end. It is understood that the bill will be paid in full or payment arrangement will be made with Lincoln Pharmacy. If no payment is received be advised that the pharmacy may suspend services at any time. As courtesy we will make an attempt to communicate either directly to responsible party or through community staff.

I hereby authorize any holder of medical and/or insurance information about the named resident to disclose such information to Lincoln Pharmacy. I further authorize Lincoln Pharmacy to disclose any medical and/or insurance information concerning the named resident in its possession to other professional personnel involved in patient care such as physicians, nurses or other such personnel. Any disclosure will be made in compliance with HIPAA guidelines and other state and federal regulations.

I request at this time Lincoln Pharmacy Provide: (please initial all that apply)
*Please note that any medications supplied are not in child proof packaging unless requested.

_____ All Medications/PRN Medications
*(to include OTC/copays)
_____ Requested Medications ONLY
_____ Incontinent Supplies as requested
_____ Diabetic Supplies as requested
*(most testing supplies to be picked up at pharmacy)
_____ Equipment as requested
_____ Other: ______________

Resident Signature: ______________________ Date: ______________
Responsible Party: ______________________ Date: ______________
Community Name: ____
Community Representative: ______________________ Date: ______________

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Community Name: ______________________________ Date: ______________

Resident Name: ______________________________ Phone: ______________

Resident Address: ____

Resident DOB: ____________________ Resident SSN: ________________

Responsible Party: ____________________________ Phone: ______________

Billing Address: ____

Primary Care Physician: _______________________ Phone: ______________

Specialty Physician(s): ________________________ Phone: ______________

________________________ Phone: ______________

Primary Insurance: ____________________________ ID# ______________

Secondary Insurance: __________________________ ID# ______________

PLEASE ATTACH BOTH SIDES OF INSURANCE CARDS &
PHYSICIAN SIGNED MEDICATIONS LIST

Allergies:

________________ ________________ ________________
________________ ________________ ________________

Diagnosis:

________________ ________________ ________________
________________ ________________ ________________
________________ ________________ ________________
________________ ________________ ________________

Pharmacy Providing:
(initial all that apply)

_____ All Medications
_____ Requested Medications ONLY
_____ Incontinent Supplies
_____ Diabetic Supplies
_____ Requested Equipment
_____ Other: ________________

I understand that Lincoln Pharmacy will attempt to bill insurance for all medications, equipment and supplies provided to the above listed resident. I agree to assume responsibility for paying all charges incurred.
This form acknowledges that the packaging Lincoln Pharmacy will be providing is not child proof.

Signature: ______________________________ Date: ______________
Printed Name: ____