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: _____ email: _____

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 prescription 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.

Statements 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 HIPPA 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 child proof packaging unless requested.

_____ All Medications/PRN Medications
*(to include OTC/Non covered items/copays)
_____ Requested Medications ONLY
_____ Incontinent Supplies as requested
_____ Diabetic Supplies as requested
*(all testing supplies have to be picked up)
_____ Equipment as requested
_____ Other: _____

Resident Signature: _____ Date: _____

Responsible Party: _____ Date: _____

Community Name: _____ Date: _____

Address: _____

Community Representative: _____ Phone: _____