McNeill's Pharmacy

North Carolina's Oldest Pharmacy

Thank you for choosing McNeill's Pharmacy to care for you! We look forward to having you as part of our McNeill's Pharmacy family. Please feel free to reach out to our pharmacy staff with any questions or concerns you may have, we are always here to assist you!

Attached are forms that you must complete for the pharmacy to begin to process, fill, package, and provide you with your medications. These documents will also be utilized to create your patient profile. These forms are confidential and will be kept on file at McNeill's Pharmacy for pharmacy personnel only. Please complete the following forms and fax to the pharmacy.

Sincerely,

McNeill's Pharmacy

Phone: 910-642- 3065 ***Fax: 910-642-3765***

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Welcome to the McNeill's Pharmacy Mail Order Prescription Benefit Program! Liberty Healthcare has designed this benefit to provide you with state of the art prescription service along with the opportunity to experience tremendous cost savings. A brief outline of the program & cost breakdown is illustrated below:

How to Use the Mail Order Program:

1. If you need to start your medication immediately, have your physician complete two prescriptions, one written for a 30-day supply and one for a 90-day supply. Fill the 30-day prescription immediately at a pharmacy convenient for you and have the 90-day prescription sent to McNeill's Pharmacy for a supply determined by your benefit plan.
2. Complete the included forms and fax to McNeill's Pharmacy. If your plan includes dependent coverage, please fill out the dependent table provided even if you are not ordering their medications at this time.
3. Please fax the following documents once completed to McNeill's Pharmacy at the fax number provided. In the future as you visit your physician, please have all prescriptions written for 90 day supplies and sent to McNeill's Pharmacy!

Pharmacy Co-Pays for Mail Order Employees:

Prescription Type	30-Day Supply (Retail Pharmacy)	90-Day Supply Mail Order (McNeill's Pharmacy)	90-Day Supply Retail Pharmacy
Generic	$10.00	ZERO - $0.00	$30.00
Preferred Brand	$20.00 +	$30.00 +	$60.00 +
Non-Preferred (Single Source)	The greater of $50.00 or 25% of cost	The greater of $50.00 or 25% of cost	The greater of $150.00 or 25% of cost

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PATIENT DEMOGRAPHICS & INFORMED CONSENT

On behalf of McNeill's Pharmacy, thank you for allowing us to play a vital role in the management of your health! By completing the following information, you are allowing McNeill's Pharmacy the right to receive, process, fill, dispense, and/or mail your prescriptions to you or a person designated to managing your care.

Patient Information:

First Name: _____ Middle Name: _____

Last Name: _____

Date of Birth: ___/___/___ Sex/Gender (circle): Male / Female

Current Address:

Street: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Allergies: _____

Caregiver/Other Contact:

Name: _____

Relationship to Patient: _____

Home Phone: _____ Mobile Phone: _____

Primary Care Provider:

Name:_____ Office Number:_____

Previous Pharmacy:

Name: _____ Phone Number: _____

By my signature below, I authorize consent that I have received information regarding the services and use of McNeill's Pharmacy. By signing I am giving permission for McNeill's Pharmacy to receive, process, fill, and dispense my prescriptions.

Print Name: _____

Signature: _____ Date: _____

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YOU MAY FILL OUT THE INSURANCE INFORMATION TABLE AND FAX TO US OR SIMPLY FAX A PHOTO OF THE FRONT & BACK OF YOUR INSURANCE CARD WITH THIS INFORMATION PACKET.

Insurance Information

BIN	
PCN	
Group Number	
ID Number	

Card Information for Medication Copay

Name on Card	
Credit or Debit	
Credit Card Number	
Expiration Date	
CVV Code	

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Safety (Child Resistant) Container Waiver

Patient Name: _____ *Date*_____

I voluntarily request that McNeill's Pharmacy (located at 620 Jefferson Street, Whiteville, NC 28472) package ALL of my prescriptions in non-safety/non-child resistant containers. I understand and acknowledge that all drugs should be kept out of reach of children and that misuse of the prescription by me, or others, may cause serious side effects, injury, or death.

I assume all responsibility for the use of non-safety/non-child resistant containers for my prescriptions and will not hold McNeill's Pharmacy liable for any adverse event that may result from misuse of my prescriptions due to the execution of this waiver.

_____ _____

Signature of Patient/Legal Representative *Date*

_____ _____

Witness *Date*

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EMPLOYEE DEPENDENT INFORMATION

Please list your eligible dependents in the table provided.

Name	Relationship	Date of Birth	Phone Number	Physician Name & Number