MEDI-MART
LONG TERM CARE PHARMACY

FACILITY: _____ **ROOM NO:** _____

DATE MEDICATIONS ARE REQUIRED (START DATE): _____

RESIDENT INFORMATION

NAME _____

SOCIAL SECURITY # _____

BIRTHDATE _____

ALLERGIES _____

_____

INSURANCE INFORMATION

Include copy of the following

1. **Prescription Drug Card**
2. **Medicare Card**

PHYSICIAN INFORMATION

DOCTOR _____

TELEPHONE _____

FAX NUMBER _____

RESIDENT'S REPRESENTATIVE

NAME: _____

ADDRESS: _____

_____

_____

BILLING INFORMATION

SEND INVOICE TO:

RESIDENT ( ) **REPRESENTATIVE** ( )

NAME: _____

ADDRESS:

_____

_____

TELEPHONE _____

1821 N. Campbell Rd Ste B
Royal Oak, MI 48073
P:(248)-858-2225 F:(248)-858-2527 medimartvm@gmail.com

AGREEMENT AND ACKNOWLEDGEMENT

RECEIPT OF IMPORTANT INFORMATION NOTICES:

By signing below, I acknowledge that I have received a copy of the Notice of Health Information Privacy Practices of Medi- Mart Pharmacy, Patient Rights & Responsibilities, 30 Medicare Supplier Standards, Service Availability, FAQ, Medicare Drug Coverage Rights, Complaint Form, Registration Form, Intake and Authorization Forms. Warranty.

AGREEMENT TO PAY - FOX HILLS MEDI-MART, LTD *(A/KIA* MEDI-MART PHARMACY):

I understand that by signing this agreement I accept full responsibility for payment of the charges incurred, by me or the person for whom I am financially responsible, for services or goods received. I understand that Medi-Mart Pharmacy will attempt to the best of its ability to obtain reimbursement for said services or goods directly from my insurance carrier or Medicare, if applicable, but that I will be liable for all deductibles, co-payments, and goods or services not covered by my insurance or Medicare, unless such liability Is expressly waived by State or Federal law. I agree to pay reasonable attorney's fees and costs of collection for any past due patient balances if this account is referred to an attorney for collection.

PAYMENT IS DUE THIRTY (30) DAYS FROM DATE OF INVOICE:

A late charge of 1 ½ percent per month, 18 percent per annum, (minimum charge of 50 cents), will be assessed for late payments.

Print Name: _____ Signature: _____Date: _____

Medicare Part B Patient Intake Form

In order for us to submit your claims to Medicare for reimbursement, the following information is required. Please complete the following information in its entirety and return it to the pharmacy.

Last Name: _____First Name:_____
Middle Initial_____ Generation: example, Jr., Sr., etc.: _____
(ONLY IF it appears on your Medicare Card)

Medicare Card#:_____Part B Effective Date: _____
(EXACTLY as it appears on your Card)

Patient SSN: _____D.O.B:_____Sex: _____

Address: _____
(Permanent Address on file with Medicare)
State: _____Zip Code: _____Telephone: _____

DO YOU HAVE CURRENT MEDICAID COVERAGE? YES ( ) OR NO ( )

If Yes, Which State Issued Your Medicaid Card: _____

Medicaid Card I.D. #: _____

DO YOU HAVE SECONDARY INSURANCE COVERAGE Such as a Medi Gap Plan? YES ( ) OR NO ( )

If Yes, Insurance Name: _____Card I.D. #_____
Primary Physician Name _____
Address: _____

City: _____State: _____Zip: _____

Telephone: _____ Fax: _____

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MEDI-MART
LONG TERM CARE PHARMACY

Authorization Form
Statement to Permit Assignment of Medicare/Medigap Benefits

I understand that I am giving **Fox Hills Medi-Mart, Ltd** permission to ask for Medicare/Medigap payments for my medical care, including supplies and equipment.

I understand that Medicare/Medigap Insurer needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to Medicare/Medigap Insurer and the companies that handle Medicare/Medigap payment requests.

I understand that the Centers for Medicare & Medicaid Services (CMS) are the government's Medicare agencies. I understand that a photocopy of this release is as valid as the original document. Furthermore, I understand that I am responsible for paying any deductible or co-insurance amounts.

Therefore, I ask that payment of authorized Medicare/Medigap benefits be made to either me or on my behalf to **Fox Hills Medi-Mart, Ltd** for any services or items furnished to me by **Fox Hills Medi-Mart.** I authorize any holder of medical or other information about me to release such information to the Centers for Medicare & Medicaid Services (CMS)/Medigap Insurer and its agents as needed to determine these benefits or benefits for related services.

Name: _____ **Medicare#:** _____

Medigap Policy Name: _____ **Policy Number**_____

Signature: _____ **Date:** _____
(Beneficiary's Signature)

MEDICAL RELEASE FOR CLAIMS

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Fox Hills Medi-Mart, Ltd for any services furnished to me by that Supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature: _____**Date:** _____

Patient Full Name: _____ Print Name: _____

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MEDI-MART
LONG TERM CARE PHARMACY

PAYMENT OF ACCOUNT

I hereby authorize Somerset Specialty Pharmacy/Fox Hills Medi-Mart to conduct credit/debit entries from my account indicated below. You will receive a monthly statement of medications and supplies along with the charge/debit receipt in the mail. If you have any questions, please contact us. All information is kept strictly confidential. Please print all information.

Patient Name _____DOB_____

Name as it appears on Account/Card _____

CREDIT CARD AUTHORIZATION

Card Type: VISA ( ) MASTER CARD ( ) DISCOVER ( ) AMERICAN EXPRESS ( )

Card Number _____

Exp. Date _____ CVV _____

Billing Address

Street_____

City _____ State _____ Zip_____

Phone _____

ACH AUTHORIZATION

Financial Institution: _____

Address: _____

Routing Number: _____ Account Number: _____

Type of Account: ( ) Checking ( ) Savings ( ) *Include copy of voided check*

I hereby authorize to Somerset Specialty Pharmacy/Fox Hills Medi-Mart Pharmacy to charge/credit the above credit/debit account for charges incurred on a monthly basis. I certify I have authority to make purchases on the account listed *above.* This authority is to remain in *effect* until written 30-day notification of termination.

Signature _____ Date _____

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