

PHARMACY SERVICE AGREEMENT

Providing Pharmacy: West TN Pharmaceutical Care
1926 Emporium Drive Suite A
Jackson, TN 38305-6063
731-554-(WTPC) 9872
Fax : 731-554-9874 email: fax@wtnpc.com

In order that the below named long term care patient may receive the proper medications when needed, this agreement is provided so that a charge account with the providing pharmacy may be established.

NAME OF PATIENT: _____ **DATE OF BIRTH:** _____

ADDRESS OF PATIENT: _____ **GENDER:** ___ **MALE** OR ___ **FEMALE**

CITY, STATE, ZIP CODE: _____

PHONE NUMBER: _____ **SOCIAL SECURITY #** _____

ANY KNOWN DRUG ALLERGIES: _____

ANY OTHER ALLERGIES: _____

NAME OF SUPPORTED AGENCY/FACILITY: _____

PHONE NUMBER OF SUPPORTED AGENCY/FACILITY: _____

PLEASE FAX, EMAIL OR DROP BY IN PERSON A COPY OF ANY INSURANCE CARDS, SUCH AS MEDICARE, MEDICARE SUPPLEMENT, MEDICARE PART D, TENNCARE, ETC.

AGREEMENT: The undersigned agrees that West TN Pharmaceutical Care is hereby authorized to provide pharmacy services as ordered by the long term care facility shown above for the enrolled patient, and that the pharmacy is to bill those charges on a monthly basis to the undersigned responsible party. The responsible party further agrees to make payments promptly to the providing pharmacy at the address indicated above for all charges billed. The responsible party is also to inform the pharmacy of any changes in billing address or if patient has transferred to another facility.

NAME OF RESPONSIBLE PARTY: _____

ADDRESS: _____

CITY, STATE, ZIP CODE: _____

PHONE NUMBER: _____

RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____

DATE: _____

PLEASE MAIL COMPLETED FORM AND ANY NECESSARY DOCUMENTS TO : WEST TN PHARMACEUTICAL CARE AT THE ADDRESS LISTED AT TOP OF THIS FORM OR FAX TO: 731-554-9874 OR SCAN & EMAIL TO: fax@wtnpc.com
Thank you.