# New Resident Admission Procedure

- Have new resident or responsible party complete and sign the Resident Billing Information Form, Pharmacy Purchase Agreement, and Assignment of Benefits Form. Please note, we require a valid credit card to be placed on file in order to secure the residents account. Only in the event of non-payment by the resident or responsible party will it be charged. (This is not applicable to residents receiving Medicaid benefits.)

- Fax forms to Guardian Pharmacy at (866) 328-3491, ATTN: Billing Team

- Give resident or responsible party the Welcome Letter

If you have any questions during this process, please feel free to contact the Billing Department at (417) 864-5873 or toll free at (866) 860-4179. We will be happy to assist you.

If the resident refuses to use Guardian Pharmacy, they must sign the "Use of Outside Pharmacy Waiver" and this must be faxed to us.

# RESIDENT BILLING INFORMATION FORM

**Guardian Pharmacy of Missouri**

2103 E Rockhurst • Suite 108 • Springfield, MO • 866-860-4179 • Fax 866-328-3491

Facility Name: ____________________________________________________________

Resident's name: ____________________________________________________________
(First) (Middle Initial) (Last)

Birth date: _____/______/_________ Social Security # ______________________________ ☐ Male ☐ Female

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## Prescription Drug Insurance Information

It is very important for you to provide Guardian with the latest **prescription insurance** information to enable accurate billing.

Do you have prescription insurance? ☐ Yes ☐ No
Do you have Medicaid? ☐ Yes ☐ No ☐ Pending (ID#________________________)
You MUST complete the information below in order for Guardian to file your insurance claims.

Prescription Insurance Plan: ____________________________________________ Cardholder ID# ___________________________

Rx Group#: ____________________________________ Rx BIN#: ________________________________

Relationship to Cardholder: ☐ Self ☐ Spouse ☐ Other ________________________________

**You MUST provide a copy of FRONT and BACK of the following items or we will not be able to process your insurance:**

☐ Prescription insurance card
☐ Medicare Card (includes Medicare Part B or Parts A & B)
☐ Medicaid Card (if applicable)

___________________________________________ (Name of person completing form)

_______________________________________ (Relationship to Resident)

**PHARMACY PURCHASE AGREEMENT**
**Guardian Pharmacy of Missouri**
2103 E Rockhurst • Suite 108 • Springfield, MO • 866-860-4179 • Fax 866-328-3491

This is an agreement for pharmacy services between Guardian Pharmacy of Missouri and

_______________________________________ and _______________________________________
(Resident) (Responsible Party other than resident)

I agree to have Guardian Pharmacy supply prescription, non-prescription medications and treatment items and other medical supplies to me as prescribed by a physician or mid-level practitioner (NP/PA) while at the listed facility. I agree that the personnel of the facility are authorized to order/purchase prescription, non-prescription medications, treatment items and other medical supplies on behalf of the above named resident. I understand that Guardian Pharmacy will bill Medicare, Medicaid, and other third party insurance carriers when applicable and that I will be responsible for co-payments and other charges not covered by these insurers. I agree to notify Guardian Pharmacy of any changes in insurance plans or insurance information, change in responsible party address or telephone number within 30 days of the change date. I understand that all accounts are due and payable within 30 days of the statement date and that Guardian Pharmacy reserves the right to terminate medication services at any time due to issues of non-payment or partial payment. I agree to pay for all collection procedures, including court costs and attorney's fee, if necessary, in order to collect any and all delinquent balances. I understand that finance charges of 1.5% per month may be charged on all past due balances over 30 days. I agree that if I (resident) go on a leave of absence or am discharged home that medications may be sent with me (resident) in non-child proof containers and that I am waiving the right to counseling on those medications.

Notice of Privacy Practices: http://guardianpharmacymissouri.com/forms/

☐ **I certify that I have had an opportunity to review Guardian's Privacy Notice at the above listed internet link and ask questions to assist me in understanding the rights relative to the protection of the above-named person's health information. I am satisfied with the explanations provided to me and I am confident that the above-named entity is committed to protecting my health information.**

**Signed Responsible Party:** _______________________________ **Date:** _______________

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**A valid credit card is required and kept on file to secure this account.**

Type of card (circle): **Visa / MasterCard / American Express / Discover**

**Name on Card**: _______________________ **Billing Address**: _______________________

_______________________

**Card #** _______________________ **Expiration** _________ **Security Code*** _________

* **VISA/MC/Discover**: 3-digits on back of card
* **Amex**: 4-digits on front of card

☐ **I wish to pay automatically by credit card each month.** I authorize Guardian Pharmacy to charge my credit card for the balance of charges not paid by my insurance company. Guardian will charge the balance due approximately 10 days after statements have been mailed to allow time to review the statement and communicate any issues/concerns.

☐ I will mail in payment by check promptly after receipt of Guardian's statement. I understand my credit card will only be used after Guardian notifies responsible party about non-payment of an outstanding balance.

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**Responsible Party for Payment & Primary Contact Person – <u>Your Statement will be mailed to this address:</u>**

Name: _______________________ Phone: _________________ (Home/Cell) Email: _________________
Circle

Address: ___________________________________________________________
(Street) (City) (State / zip)

***As a patient of <u>Guardian Pharmacy of Missouri</u> you acknowledge that you understand the following:***

Beneficiary Name (Printed): ______________________________________________________

Date of Birth: _____/______/___________ Social Security #: ___________________________
Month Day Year

## AUTHORIZATION ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I certify that the information I furnish is true and correct. I know it is a crime to fill out this form with facts that I know are false or to leave out facts that are important. I hereby authorize **Guardian Pharmacy of Missouri** to submit a claim to my insurance carrier or its intermediaries for all covered prescriptions or durable medical equipment and authorize and direct my insurance carrier or its intermediaries to issue payment directly to **Guardian Pharmacy of Missouri**. I hereby authorize **Guardian Pharmacy of Missouri** to furnish complete information requested by my insurance carrier or its intermediaries regarding services rendered. I further agree that I am responsible for paying my co-pays or balances which remain after insurance payments have been made, including any cost of collection or legal fee incurred to collect these balances. I agree that Guardian Pharmacy may contact me in the future, via telephone or other means of communication, regarding ordering medical supplies.

## ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare benefits be made to me or on my behalf to **Guardian Pharmacy of Missouri** for prescription medications or durable medical equipment and supplies ordered by my physician. I authorize any holder of medical information about me to release to the Center for Medicare Medicaid Services and it's agency any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If 'other insurance' is indicated in item 9 of the HCFA-1500 claim form, or elsewhere on the approved claim form or electronically submitted claims, my signature authorizes releasing the information to the insurer or agency listed. In Medicare assigned cases, the supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered items. Coinsurance and the deductible are based upon the charge determination to the Medicare carrier.

______________________________________ ________________________
Beneficiary or Responsible Party Signature Date

______________________________________ ________________________
Responsible Party Printed Name Relationship to Beneficiary
(if Beneficiary Unable to Sign)

***This form kept in Patient Record***