Insurance Information

Resident:_____

Community/Facility:_____

****Resident Medicare Part B#**_____ (Please include a copy of card)

****Resident Prescription Insurance:**

NAME OF PRESCRIPTION CARRIER:_____

PHONE NUMBER:_____

CARDHOLDER NAME:_____

BIN#_____(usually 6 digits) PCN#_____

ID#_____ GROUP#_____

****Secondary Insurance (including Medicaid) if applicable**

NAME OF PRESCRIPTION CARRIER:_____

PHONE NUMBER:_____

CARDHOLDER NAME:_____

BIN#_____(usually 6 digits) PCN#_____

ID#_____ GROUP#_____

I, _____ resident/representative (circle one) request that payments for services provided by **MASSPACKLtc PHARMACY** to the resident named above and that are covered by the benefit coverage provided be made directly to **MASSPACKLtc PHARMACY.**

I agree to be fully responsible for all charges, copayments, deductibles, and fees charged to the resident after proper claim submission to Medicare, Medicaid, and private insurance plans. I understand that **MASSPACKLtc PHARMACY** is not responsible for deductibles and any other excessive fees assigned by residents' third party plans. All pharmacy related charges will be invoiced separately from any other services received at the community and payment shall be made directly to **MASSPACKLtc PHARMACY**.

This authorization will remain in full force for current and future services provided by **MASSPACKLtc PHARMACY** unless revoked by resident/representative in writing.

_____ _____

Resident/Representative Signature Date