ROCKHILL PHARMACY
LONG TERM CARE SERVICES

Authorization for Pharmacy Services

Individual Information

All fields MUST be completed

First Name:______________________ Last Name:__________________________SSN:_________________

Facility/Agency:_________________________________ Unit/ISL:__________________________________

DOB: ___________Gender: ____Drug Allergies:____

Insurance Information

Attach copy of card(s)

☐ **Check here if OK to send non-covered items**

Primary: _____________________________________ Secondary: _________________________________

Group#: _____________________________________ Group#: _________________________________

ID#: _____________________________________ ID#: _________________________________

BIN#: __________ BIN#: _________

Billing Information (Copays, OTCs, Non-Covered)

All fields MUST be completed

NOTE: Pharmacy will bill insurance for covered medications, and is required to collect copayments and non-covered costs, including OTC charges, from the payer listed below.

☐ Kansas City Regional Office: 821 Admiral Blvd, Kansas City, MO 64106

☐ Public Administrator – please specify which county:_____________ ____________________________

☐ Other Guardian: ____

Mailing Address: ____

City: ____ State: ________ Zip Code: ______________

Phone: ____________________________________ Email: _______________________________________

Relationship to Individual:____

A monthly statement of activity listing co-payments and all non-covered items will be mailed monthly to the financially responsible party indicated above. Payment in full is due by the 1st day of the following month, and is accepted via check/money order or credit card payments can be processed via www.rockhillpharmacy.com. Delinquent accounts are subject to a finance charge of 2% per month.

I agree that in order for my account to remain active, payment for billed charges must be made promptly pursuant to the above terms. I agree to pay all costs of collection, including court costs and attorney fees for all delinquent balances.

I acknowledge and agree to comply with the billing and payment terms as detailed in this section.

Individual's or Responsible Party's Initials: ______

Individual's/Responsible Party's Signature: ____________________________________Date: ________