P H A R M A C Y
A U T H O R I Z A T I O N

Resident Name_____ **Admit Date**_____

Facility_____**Rm#**_____**Physician**_____

Soc. Sec. #_____ **D.O.B.**_____

Drug Allergies: _____

Medicare Part A Yes **Medicare #**_____

Medicaid Pending Yes **Medicaid #**_____

Private Paying Resident: Yes

Private Insurance Plan: _____

Is resident enrolled in a Medicare Part D Insurance Plan?

If yes, what Medicare Part D plan? _____

If not enrolled, would you like the facility to assist you in enrolling the resident in a Medicare Part D plan?
If yes, what Medicare Part D plan? _____

Pharmacy MUST have a <u>front and back</u> copy of the patient's insurance cards, Medicare card, and Medicare Part D card at the <u>time of admission</u>.

Responsible Party_____

Address _____

_____

Phone _____

By signing this form, I acknowledge that I have been given a choice in pharmacy services. I authorize the Nursing Facility to order medications for the above named resident from: _____. I will be responsible for charges not covered by Medicare, Medicare Part D, Medicaid, or private insurance.

Signature _____

Relationship to Resident _____ **Date** _____