Medication Management PARTNERS

PERFECTLY SCRIPTED

RESIDENT SERVICE AGREEMENT FORM

DATE: _____ COMMUNITY: _____ APT #: _____

RESIDENT NAME: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

MEDICARE #: _____ MEDICAID#: _____

PLEASE INCLUDE A COPY OF ALL PRESCRIPTION INSURANCE CARDS

POA/RESPONSIBLE PARTY NAME: (please print) _____

POA/RESPONSIBLE PARTY ADDRESS: _____

_____

POA/RESPONSIBLE PARTY **CELL PHONE** #: _____ EMAIL: _____

NOTE: ALL STATEMENTS AND FINAL BILLS WILL BE FORWARDED TO THE ADDRESS LISTED ABOVE FOR THE RESPONSIBLE PARTY

I, the undersigned resident/POA/responsible party: authorize Medication Management Partners Inc. (MMP), to provide all pharmaceutical medications, supplies and services ordered by the resident's physician(s) ("Pharmacy Services"); direct any third-party payor to make payment directly to MMP for all Pharmacy Services provided to the resident; agree to pay for all unreimbursed charges (including copayments, deductibles, and charges resulting from unfulfilled/unapproved prior-authorization requirements, out-of-network services and non-covered medications/services), including reasonable fees and costs incurred by MMP in the collection of this account; understand that all of the resident's maintenance medications will be enrolled in auto-fill and it is my responsibility to notify MMP of any cancellation or suspension of auto-fill service; understand that medications are dispensed in non-child resistant packaging.

I UNDERSTAND THAT, WHILE MMP WILL ATTEMPT TO RECOVER AVAILABLE INSURANCE RIMBURSEMENTS, I REMAIN FINANCIALLY RESPONSIBLE FOR ALL PHARMACY SERVICES, SUBJECT TO APPLICABLE LAW. I FURTHER AUTHORIZE THE PHARMACY TO PROVIDE PHARMACY SERVICES DEEMED URGENT WITHOUT FURTHER NOTICE IN ACCORDANCE WITH THE POLICIES AND PROCEDURES IN PLACE BETWEEN THE PHARMACY AND THE COMMUNITY TO ENSURE CONTINUITY OF CARE FOR THE RESIDENT.

_____

(*Signature*)

PLEASE CHECK ONE: ( ) RESIDENT
( ) RESPONSIBLE PARTY/POA

All residents serviced by MMP are required to have a valid payment method on file and be enrolled in AutoPay. This ensures timely processing of orders and uninterrupted service. Statements will be mailed to the address listed above for your records (electronic delivery is available after the first statement is generated).

Name on Card/Account: _____

Bank Routing Number: _____ Bank Account Number: _____

Credit Card number#: _____ Expiration Date: _____ Security Code: _____

Zip Code _____