Guardian® pharmacy Minnesota

940 Industrial Dr. S., Ste. 102
Sauk Rapids, MN 56379
Phone: 320-230-1050
Fax: 320-230-1051

Split Bill Request

Date: ____________________

Submitted By: ____________________

Instructions:
1. Pull the label or write the RX# and drug name
2. Provide the quantity being sent with the patient
3. Fax to the pharmacy for rebilling

Resident Name: ____________________ Date of Birth: ____________________

RX#: Drug: Qty. Sent:	RX#: Drug: Qty. Sent:
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RX#: Drug: Qty. Sent:	RX#: Drug: Qty. Sent:
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RX#: Drug: Qty. Sent:	RX#: Drug: Qty. Sent:
RX#: Drug: Qty. Sent:	RX#: Drug: Qty. Sent:
RX#: Drug: Qty. Sent:	RX#: Drug: Qty. Sent:

Patient Signature: ____________________

By signing this form I acknowledge that I am accepting the above medications. I understand that the quantity indicated will be billed to my insurance and that I could receive a bill from Guardian Pharmacy.