Phone: 952-206-4380 Fax: 855-707-2501

New Admission Cover Sheet

To: Guardian Pharmacy _____ From: _____

Fax#: 855-707-2501 _____ Date: _____

Total no. of pages, including cover: _____

_____New Admit _____ Re-Admit (Hospital Return)

Patient Name: _____ DOB: ____/_____/_____ Room #: _____

Patient Allergies: _____

_____

Patient SS#: _____ Medicare #: _____

Primary Physician_____

Billing Information

*****Copy of insurance cards (front & back) must be sent to the pharmacy*****

_____ Facility Responsibility (Medicare A, MSHO…)

_____ Private Insurance (Medicare D, Medicaid…)

_____ Private Pay- Patient does not have any prescription drug coverage. **Page 2 must be completed.**

Responsible Party Name_____Relationship_____

Responsible Party Address_____

_____

Phone Number_____

Please remember to fax a copy of the PATIENTS FACE SHEET along with any copies of CONTROLLED SUBSTANCE PRESCRIPTIONS.

Patient Payment Guarantee Form

***** Must be completed, signed and returned to Guardian Pharmacy *****

PATIENT NAME: _____ FACILITY**:** _____

Guardian Pharmacy Minnesota (referred to herein as "Pharmacy") agrees to provide to the resident all pharmaceutical services as needed. Medication is packaged via a unit dose system.

Pharmacy will maintain a current drug profile on the resident, provide free delivery service and 24-hour emergency service. I hereby authorize these services to be rendered to the resident for whatever period of time the physician deems necessary.

In consideration for the agreement of the Pharmacy to provide medications and supplies to the above patient on an open account, (I/We) do hereby unconditionally guarantee payment to the Pharmacy for all medications and supplies purchased from the same and supplied to the above-named patient while a resident at the above name Facility.

**** Responsible Party Signature Required ****

Responsible Party (print): _____

Responsible Party (sign): _____

Date: _____