NORTHERN TIER
CENTER FOR HEALTH

NOTCH

NOTCH Pharmacy Multi-Dosage Packaging Agreement

Patient's Name: _____ DOB:_____

My signature on this form acknowledges that I have entered into a voluntary multi-dose packaging agreement with NOTCH Pharmacy. Terms of this agreement are as follows:

- NOTCH will package my prescription medications in a 28-day multi-dose format.
- NOTCH may fill shortened quantities of my prescriptions in order to make all my refills due on the same day. If necessary, I may have to pay an extra co-pay one time for each medication in order to make all refills due on the same day.
- NOTCH will only bill my insurance carrier in accordance with their contracted terms and conditions and my co-payment responsibilities will reflect this billing cycle.
- I will be auto billed once a month for copays.
- This is a voluntary agreement and may be terminated at any time.

☐ I acknowledge that it is my responsibility to verify that the medications received in multi-dose packaging reflect my current medications, dose and frequency. If the medications I received do not match my current medication, dose, and frequency I should contact my prescribing provider.

☐ I acknowledge that if I receive medications by mail and live outside of the state of Vermont for any period, I must sign up for a mail forwarding service for the period I do not live in the State of Vermont in order to mitigate any mailing and tracking discrepancies that may occur.

☐ I acknowledge that NOTCH is not responsible for packages lost in the mail, and that I (patient) am responsible for the cost of replacing medications lost or damaged in this manner.

Signature:_____ Date:_____

Please indicate relationship to patient

- ☐ Self
- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of patient
- ☐ Beneficiary or personal representative of deceased patient
- ☐ Spouse or person financially responsible *(where information solely for purpose of processing application for dependent health care coverage)*
- ☐ Other:_____

Once we receive the completed information, we will request new prescriptions from your medical providers and contact you to confirm the start date for your Multi-Dosage Packaging.

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Patient Information

Name: _____ SSN: _____ Gender: _____ DOB: _____

Address _____
City *State* *Zip*

Phone: (h) _____ (c) _____

Prescription Insurance: _____

BIN: _____ PCN: _____ Grp: _____

Member ID: _____ Medicare ID: _____

Allergies: _____

Drug Reactions: _____

Chronic Conditions or Disease State: _____

Please list any other prescription medications, vitamins or over the counter cough and cold, allergy or pain medication below. Include how often you take it (e.g., Tylenol, as needed or Baby Aspiring – one each day)

_____ _____

_____ _____

_____ _____

_____ _____

☐ I do not take other prescription medications, vitamins or over the counter cough and cold, allergy or pain medication

Method of Delivery: ☐ Pick up at Pharmacy ☐ Mail Order

Person Responsibility for Payment: _____

Shipping Address: _____
City *State* *Zip*

Phone: _____ Guardian: _____

Other Insurance: _____ Policy #: _____

Physician: _____ Phone Number: _____

Supplies Needed: _____

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ASSIGNMENT OF INSURANCE BENEFITS FORM
Multi-Dose Packaging

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE OR MEDICARE BENEFITS BE MADE ON MY BEHALF TO NOTCH PHARMACY FOR ANY PRESCRIPTIONS OR SUPPLIES FURNISHED ME BY THE PHARMACY. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE INSURANCE COMPANY OR TO CMS (CENTERS FOR MEDICARE AND MEDICAID SERVICES) AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE TO RELATED SERVICES.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. *In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services*. Coinsurance and the deductible are based upon the charge determination of the Insurance carrier.

My signature authorizes the automatic filling and refilling of all ordered medications. As a Multi-dose packaged customer, my medications will be packaged in 28-day cycles, including any medications prescribed to be taken as needed. New prescriptions and refills will be filled and billed according to my established packaging schedule.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, INCLUDING COPAYMENTS AND COSTS NOT COVERED BY SAID INSURANCE.

My signature on this form also acknowledges receipt of the *NOTCH NOTICE OF PRIVACY PRACTICES* and the *CMS MEDICARE DMEPOS SUPPLIER STANDARDS.*

Patient's Name (Print): _____ DOB: _____

Signature:_____ Date: _____

Please indicate relationship to patient

- ☐ Self
- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of patient
- ☐ Beneficiary or personal representative of deceased patient
- ☐ Spouse or person financially responsible (where information solely for purpose of processing application for dependent health care coverage)
- ☐ Other:_____

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Credit Card Authorization Form

NOTCH Pharmacy accepts Visa, MasterCard, Discover and American Express
Please complete the information listed below.

BILLING INFORMATION

Name as it appears on credit card: _____

Billing Address: _____
City *State* *Zip*

Country (if other than the United States) _____

Billing Address Phone Number: _____

CREDIT CARD INFORMATION

Credit Card type: ☐ VISA ☐ MasterCard ☐ Discover ☐ American Express

Card Number: _____ Expiration Date: _____

Security Code: _____

AUTHORIZATION FOR PAYMENT:

I authorize NOTCH Pharmacy to keep this credit card information on file. I understand this information will be used to process payments due on my account for Pharmacy purchases provided by NOTCH Pharmacy. I will notify NOTCH Pharmacy of any changes or when I no longer wish to keep my card on file.

Signature of Cardholder: _____

Signature Date: _____/_____/_____ **Phone #: (**_____**)**_____

Note: Your credit card statement will show a charge from Northern Tier Center for Health
44 Main Street, Suite 200, Richford, VT 05476 Phone: (802)255-5530 Fax: (802)255-5539

You will receive a receipt for your purchase via mail once your credit card information has been processed.