PHARMACY SERVICE AGREEMENT

Providing Pharmacy: West TN Pharmaceutical Care
24 Nolan Cove
Jackson, TN 38305-3160
731-554-(WTPC) 9872
731-554-9874 = Fax EMAIL: fax@wtnpc.com

In order that the below named long term care patient may receive the proper medications when needed, this agreement is provided so that a charge account with the providing pharmacy may be established.

NAME OF PATIENT: ____**DATE OF BIRTH:**____________________

ADDRESS OF PATIENT: ____**GENDER:**____**MALE OR** ____**FEMALE**

CITY, STATE, ZIP CODE: ____

PHONE NUMBER: ________________________________**SOCIAL SECURITY #**_______________________________

DRUG ALLERGIES/ OTHER ALLERGIES: ____

NAME OF SUPPORTED AGENCY/FACILITY & PHONE NUMBER:

____

HOME MANAGER NAME & PHONE NUMBER:____

ROOMMATE:____

NAME OF DISTRICT NURSE & PROGRAM COORDINATOR:

____

PCP:____

PSYCH MD.:____

PLEASE FAX, EMAIL OR DROP BY IN PERSON A COPY OF ANY INSURANCE CARDS, SUCH AS MEDICARE, MEDICARE SUPPLEMENT, MEDICARE PART D, TENNCARE, ETC.

AGREEMENT: The undersigned agrees that West TN Pharmaceutical Care is hereby authorized to provide pharmacy services as ordered by the long term care facility shown above for the enrolled patient, and that the pharmacy is to bill those charges on a monthly basis to the undersigned responsible party. The responsible party further agrees to make payments promptly to the providing pharmacy at the address indicated above for all charges billed. The responsible party is also to inform the pharmacy of any changes in billing address or if patient has transferred to another facility.

NAME OF RESPONSIBLE PARTY: ____

ADDRESS: ____

PHONE NUMBER: ____

RELATIONSHIP TO PATIENT: ____

SIGNATURE/DATE: ____

PLEASE MAIL COMPLETED FORM AND ANY NECESSARY DOCUMENTS TO : WEST TN PHARMACEUTICAL CARE AT THE ADDRESS LISTED AT TOP OF THIS FORM OR FAX TO: 731-554-9874