Payment Authorization Non-Covered Item

Patient: _____ Date: _____

Date of Birth: _____ Facility: _____

The medication(s) listed below is/are not covered by the patient's provider benefits or formulary (I.e. Medicare, Medicaid, Insurance). If a physician prescribes a medication that is not covered in the provider's formulary, we will submit a request for an authorization if possible, but cannot guarantee acceptance or coverage by the provider.

-If the provider denies authorization, we may be able to suggest an alternative or generic medication to the prescribing physician that is both acceptable to the physician and covered in the provider's formulary.

-If the non-formulary item must be utilized, the financially responsible party must complete the requested information below for billing purposes. This form must be returned completed to RX Pharmacy LTC before medication can be dispensed to the patient.

MEDICATION _____

COST _____

By signing below, I accept financial responsibility for the non-formulary medication(s) and associated cost listed above.

Facility (charges will be billed to the facility's house account)

Name of Authorizing Staff: _____

Title: _____

Signature: _____ Date: _____

OR

Resident, Family, Guardian, or other responsible party

Name: _____ Relationship: _____

Billing Address: _____ Phone: _____

Signature: _____ Date: _____

Fax Back to RX Pharmacy LTC 509-940-9002