Patient Admission Record

Phone: 866-367-8701 ▪ Fax: 866-367-8702
www.managedhealthcarepharmacy.com

Patient Information

Resident Name: _____ Date of Birth: _____/_____/_____
(first and last name)

☐ Male ☐ Female Social Security #: _____ -_____-_____ Service Start Date: _____

Facility Name: _____ Contact Person: _____

Facility Address: _____ City: _____ State: _____ Zip: _____

Facility Phone: _____ Facility Fax: _____

Packaging: ☐ Bubble Packs ☐ Vials (all medications will be packaged in non-child resistant bubble packs unless specified otherwise)

Allergies: _____

Diagnosis: _____

Physician Information

Physician (Last, First Name): _____

Phone: _____ Fax: _____

Secondary Physician (Last, First Name): _____

Phone: _____ Fax: _____

Contact / Billing Information

Financially Responsible Party Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Cell Phone: _____

Insurance Company: _____ Policy #: _____ Group #: _____

Bin #: _____ PCN #: _____ (this information can be found on the insurance card)

Oregon Medicaid : This patient is covered by Oregon Medicaid. I.D. #: _____

Please attach a current medication list and insurance card when faxing back to pharmacy

I understand that I am financially responsible for the payment to Managed Healthcare Pharmacy (**MHP**) for all charges incurred by the above named individual. I hereby request that payment of authorized insurance benefits be made on my behalf to MHP. All medications and supplies not covered by Medicaid, Medicare or other insurance will be billed to patient or the responsible party, unless prohibited by state regulation. **HIPAA Statement**: I authorized MHP and its agents to use and disclose protected health information (**PHI**) for the above named individual for the purpose of determining benefits for related services and applying payment. All PHI is strictly confidential according to all HIPAA guidelines. MHP's Notice of Privacy Act Policy is available on our website at www.managedhealthcarepharmacy.com. If you need further information regarding HIPAA, please contact the pharmacy at 1-866-367-8701. All PHI is strictly confidential except as released above. I request all that all medications, now and in the future, be dispensed in non-child resistant containers. By signing below, I have reviewed the statement above.

Resident/Financial Party Signature: _____ **Date:** _____