ValueMed Enrollment Form

Please complete all information and print clearly. Any missing information may cause a delay in receipt of services and supplies.

Fax the completed admissions form to:**1-800-838-9220**.

Resident Information

Community Name		
Current Pharmacy	Prescriber	
Full Name	Date of Admission / /	
☐ Male ☐ Female	DOB / /	SSN - -
Resident Email		
Resident Phone ( )	Floor #	Room #
Allergies		
Does your community administer your medications?	☐ Yes ☐ No	☐ Not Sure

Responsible Party Information

Responsible Party Name	Responsible Party Phone ( )	
Responsible Party Address		
City	State	Zip
Responsible Party Email		
☐ Medical Responsible Party ☐ POA	☐ Spouse	☐ Financial Responsible Party ☐ Family Member

Responsible Party Name	Responsible Party Phone ( )	
Responsible Party Address		
City	State	Zip
Responsible Party Email		
☐ Medical Responsible Party ☐ POA	☐ Spouse	☐ Financial Responsible Party ☐ Family Member

FAX COMPLETED FORM TO: 1-800-838-9220

If you have questions or need assistance, please feel free to call our ValueMed Pharmacy at 1-800-880-6996.

Agreement to Pharmacy Services and Financial Responsibility

This agreement is entered into this day, between ValueMed ("Pharmacy") and the Resident and Responsible Party listed above who agree as follows:

1. The Pharmacy shall provide pharmacy services and supplies to the Resident on an open account and will provide the Responsible Party a listing of the medications supplied, and date of service.
2. The Resident and Responsible Party agree that they will be both individually and jointly responsible for paying to the Pharmacy any sums due for pharmacy services and supplies furnished to the Resident that are not reimbursed by outside sources, and the Responsible Party hereby guarantees that the pharmacy will be paid all sums due.
3. The Pharmacy will submit bills to the appropriate participating insurance plan or other reimbursement programs.
4. The Pharmacy will charge Resident or the Responsible Party for any co-payments and non-covered or un-reimbursed medications.
5. This Agreement shall bind the person or persons signed below. If signed by only the Responsible Party, it shall be binding on that party without regard to absence of the Resident's signature. If signed by only the Resident, the Resident shall be considered to be both the Resident and the Responsible Party for the purposes of this Agreement. Intending to be legally bound hereby, the Resident and Responsible Party have/has executed this Agreement providing for payment and guarantees of the sums due the Pharmacy for provision of pharmaceuticals and pharmacy services to the Resident on the date indicated below.
6. You consent to receive pharmacy services and supplies from ValueMed.

I authorize ValueMed to bill my account for pharmacy services. I may discontinue this agreement at any time by contacting ValueMed Pharmacy. If your responsibility is less than $500, ValueMed will send your prescription. If your total out of pocket for all medications exceeds $500 at any time, ValueMed will call you to request payment until this balance is below the threshold.

Resident or Responsible Party Signature
Date (mm/dd/year) / /

INSURANCE INFORMATION

Please attach a copy of all insurance cards, both front and back.

FAX COMPLETED FORM TO: 1-800-838-9220

If you have questions or need assistance, please feel free to call our ValueMed Pharmacy at 1-800-880-6996.

Payment Authorization: Credit/Debit Card

Please complete and fax this form to **1-800-838-9220.**

Payment authorization will remain in effect with ValueMed as long as you use ValueMed pharmacy services to receive your medications.

General Information

Resident Name	Resident Phone ( )
Responsible Party Name	Relationship to Resident
Responsible Party Phone ( )	Alternate Phone ( )
Responsible Party Email	

Billing Address

Address		
City	State	Zip

Credit/Debit Card Information

Cardholder Name				
☐ Visa	☐ MasterCard	☐ Discover	☐ American Express	
Credit Card #		Exp. Date (mm/year) /		Security Code
Responsible Party Email				

Authorization

☐ I authorize ValueMed to automatically charge the above credit/debit card each month for pharmacy services for the resident. ValueMed will send a monthly statement copy each month to review. I may discontinue this automatic monthly payment agreement at any time by calling ValueMed at 1-800-880-6996.
Resident or Responsible Party Signature
Date (mm/dd/year) / /

FAX COMPLETED FORM TO: 1-800-838-9220

If you have questions or need assistance, please feel free to call our ValueMed Pharmacy at 1-800-880-6996.