St. Matthews
Specialty Pharmacy
A CORDANT HEALTH SOLUTIONS® COMPANY

PATIENT AUTHORIZATION
PLAN OF CARE / SERVICE

Patient Name: _____ **Date of Birth:** _____

Insurance payment authorization: I request that Medicare and/or any other insurance plan that I have to make payments of authorized benefits on my behalf directly to St. Matthews Specialty Pharmacy for pharmaceuticals/equipment/supplies that were furnished to me for which they bill Medicare and/or any other insurance plan on my behalf.

Release of insurance information: I request my medical insurance plan(s) to release to the above-named company, any and all information which will assist in processing my claims for pharmaceuticals, equipment and/or medical supplies that I am receiving from the above-named company even after service to me is discontinued. I also authorized any holder of hospital or medical information about me to release to the health care financing administration, its agents, my insurance company or the above-named company any information needed to determine the benefits that are payable for related services.

I understand if my insurance plan(s) makes payment(s) to me for pharmaceuticals, equipment and/or medical supplies that I have received, rather than directly to the above-named company, I agree to endorse those checks and send them immediately to the above-named company.

I also understand that I am responsible for the payment of any deductible, co-insurance or other portion of my charges not paid by my insurance plan(s). I also understand that I may be eligible for a partial or complete waiver of any unpaid co-insurance charges only, under St. Matthews Specialty Pharmacy financial hardship program.

_____ **(Initials) I acknowledge that I have been advised of my financial obligations to St. Matthews Specialty Pharmacy including co-pays, deductibles and any anticipated denials for products furnished by St. Matthews Specialty Pharmacy.**

I hereby agree that St. Matthews Specialty Pharmacy or any of its affiliates may contact me at my place of residence or cellular telephone, my authorized caregiver and/or emergency contact by telephone. I agree to enter into the patient management program at St. Matthews Specialty Pharmacy.

I have reviewed and understand the information above. I have been instructed on and understand the use of the products provided. I have received a copy of a patient handout that contains a welcome letter, patient rights and responsibilities, information on access to pharmacy services, HIPAA privacy notice, emergency planning, making decisions about your health care, grievance/complaint information and drug safety and disposal techniques. I have received the medication monograph/drug education information and, if applicable, equipment and medical supply instructions, warranty information. I have received instructions on how to contact St. Matthews Specialty Pharmacy.

I understand that prescribed medications cannot be re-dispensed. By law, these items cannot be returned for credit.

I understand the limitations of the patient management program, including that they do not supplant physician advice or interactions and are subject to my compliance and willingness to participate.

I understand that I may lodge a complaint without concern for reprisal, discrimination, or unreasonable interruption of service with the pharmacy directly at 844-690-4462 or the compliance hotline at 833-222-4169.

Identified needs/problems: I understand I may be unfamiliar with use of the medications, equipment and/or medical supplies provided. Expected outcomes: The patient will be provided the pharmaceuticals, equipment and/or medical supplies to comply with the prescriber's prescription. I will use the medication(s), equipment and/or medical supplies as prescribed. I will know how to obtain follow-up services as needed.

PATIENT OR RESPONSIBLE PARTY SIGNATURE: _____

PRINT NAME: _____ **DATE:** _____

Please return in the envelope provided, fax or email. Thank you for choosing St. Matthews Specialty Pharmacy!

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