VOLUNTEER
PHARMACY

Receipt of Medication & Copay Form

Thank you for allowing our pharmacy to serve you, it is truly our pleasure.

If you wish to CONSULT with our PHARMACIST, please call on any medications anytime at 800-690-8980.
You may submit this form to confirm receipt of your prescription. This must be done with every refill as well for insurance purposes. **Your insurance company may refuse payment unless you sign and return this form at your earliest convenience.**

Your signature on this form certifies you received a service or item dispensed on the date(s) listed and that the information contained hereon is correct and that the person for whom the prescription was written is eligible for the benefits. You also certify that you have received the medication identified below and authorize release of all the information contained on this log and prescription to which it corresponds, to the plan administrator, the underwriter, the sponsor, the policyholder, the Workman's Compensation Commission (if applicable), and the employer. You hereby assign to this provider pharmacy any payment due pursuant to this transaction and authorize payment directly to this provider pharmacy. In addition: You understand that if payment for this service or item will be from Federal and State funds and that any false claims, statements or documents, or concealment of material facts may be prosecuted under applicable Federal and State Laws. Furthermore, as required by State Laws you acknowledge receipt of an OFFER TO COUNSEL and have accepted or refused counseling as indicated. WORKERS COMPENSATION ONLY: Your signature on the reverse side of this card certifies that this medication is for the treatment of an on-the-job injury. ALL OTHER THIRD PARTY PROGRAMS: Your signature on this form certifies that this medication is not for treatment of an on-the-job injury.

As permitted by law, the undersigned:

Patient Name _____ Date of Birth: _____
Street _____
City/St/Zip _____
Phone _____

Certifies that they received prescriptions and pharmacy care services from the list below. Additionally, the undersigned authorizes the release of all information contained in this acknowledgment, the prescription(s) and service(s) to which it corresponds and subsequent claim to all parties concerned. The undersigned acknowledges reading and understanding the patient waivers and authorization on this form. The undersigned also acknowledges receiving an offer to consult with a pharmacist regarding my medications and the receipt of the following pharmacy services shipped on:_____(DATE).

Date of Fill	Rx Number	Medication

X Signature: _____ Date: _____

❑I affirm that copay of $_____ was paid by (circle one) -check- -credit card- -cash- -other-

❑I affirm that an early refill was requested as a vacation supply as I was traveling to_____
(location) for the following dates _____ to _____

❑I affirm that an early refill was requested as a replacement of lost/stolen/damaged medication

❑I affirm that I requested that pharmacy dispense brand name only (DAW-2)

X _____ _____
Beneficiary Signature ***Date***