VOLUNTEER PHARMACY

2559 Willow Point Way, Knoxville, TN 37931
Phone: 865-560-0135 * Toll-free 800-690-8980 * Confidential textline: 865-999-0298
Fax: 865-694-4489 * Email: info@volunteerpharmacy.com * website: www.volunteerpharmacy.com

Receipt of Medication & Copay Form

For your convenience, this form is also available to submit online! Go to www.volunteerpharmacy.com then click on "For Patients" then "Receipt of Medication Confirmation" to access the form.

If you wish to CONSULT with our PHARMACIST, please call us at 800-690-8980. Please complete and return this form to our pharmacy in order to confirm receipt of your prescription. This form may be returned to us by mail, email, text, or fax. 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.

As permitted by law, the undersigned:

Patient Name _____ Date of Birth: _____

Street _____City/St/Zip _____

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

Choose your way to pay:

Auto Pay	**Pay Online**	**Pay by Mail**	**Pay by Phone**
When you sign up for Auto Pay, your monthly co-pay is automatically charged to credit card or debit card on file. Call 800-690-8980 to sign up.	We can send your invoice by text or email! *Quick Tip: Use our textline at 865-999-0298 to text your request to us that you want your invoice by text or email*	Mail check to: Volunteer Pharmacy 2559 Willow Point Way Knoxville, TN 37931 **Make checks payable to Volunteer Pharmacy**	Call 800-690-8980 and let our staff know you would like to make a payment.

__ I would like my medication auto-filled monthly

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

- Total copay amount $ _____

Patient or Guardian Signature: _____ **Date:** _____