Pharmacy Home Delivery

Phone: **800-862-1456** P.O. Box 668, Roswell, GA 30077 **Fax:** **888-805-2406**

Permission to Contact & Assignment of Benefits

Name_____

Address_____

City, State, Zip_____

Phone_____-_____-_____ **Allergies**_____

Medicare # __ __ __--__ __--__ __ __ __--__ **Birth Date** _____-_____-_____

Insurance Information – circle answer

Self Pay yes no	Medicaid yes no
Drug Card yes no	VA yes no

Card Name_____

Co-pay Generic $_____Brand$_____

Optional **$** _____ year

Combined Family Income needed to qualify for free drug programs and the new Medicare Part D Drug Card

X_____ _____/____/_____

Patient or Guardian Signature Relationship if Signed by Guardian Signature Date (Required)

I authorize Pharmacy Home Delivery, LLC (PHD) to contact me and to get my medical information from my Ins. Co. doctor, HHA, hospital or pharmacy as needed. I assign my insurance benefits (AOB) to PHD to directly submit claims on my behalf and to be paid to PHD by Medicare, Medicaid or other insurers (agents or assigns)for products or medications they supply to me at my request I understand that I am responsible for any co-payments, deductibles and non-covered services. I authorize PHD and it's pharmacy to choose a delivery service, common carrier, US Mail or like service to act on my behalf as my "designee" for receiving and delivery of my orders to my address. I authorize that the tracking number provided by the designee shall act as my signature for any pharmacy log or financial transaction requirements. If I decide to pay PHD via credit card or electronic check I authorize PHD to continue future transactions for varying amounts as each order I place requires until cancelled by me and photo copies shall be valid as originals. ANY PART OF THIS AUTHORIZATION MAY BE CANCELLED AT ANY TIME.

Fax to 1-888-805-2406

The solution to the high cost of Prescription Drugs