



Pharmacy Home Delivery

Phone: **800-862-1456** 110 Keith ST SW, Suite 1, Cleveland, TN 37311

Fax: **888-805-2406**

Permission to Contact & Assignment of Benefits

Name _____		Insurance Information – circle answer	
Address _____		Self Pay yes no	Medicaid yes no
City, State, Zip _____		Drug Card yes no	VA yes no
Phone _____ - _____ - _____ Allergies _____		Card Name _____	
Medicare # ____ - ____ - ____ - ____ - ____ Birth Date ____ - ____ - ____		Co-pay Generic \$ _____ Brand \$ _____	
X _____		Optional \$ _____ year	
Patient or Guardian Signature Relationship if Signed by Guardian _____		Combined Family Income needed to qualify for free drug programs and the new Medicare Part D Drug Card	
_____		_____ / _____ / _____	
Signature Date (Required)			
<p>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.</p>			

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The solution to the high cost of Prescription Drugs