# Sign-up Form

ValueMed

Please complete all information and print clearly. Any missing information may cause a delay in receipt of services and supplies. Fax the completed admissions form to: **1-855-879-2669.**

## Resident Information

| | | |
|---|---|---|
| Facility Name | Prescriber | |
| Full Name | Date of Admission / / | ☐ Male ☐ Female |
| DOB / / | SSN - - | |
| Resident Phone ( ) | Resident Email | |
| Station Name or Number | Room Number | Bed Number |

## Insurance Status

Please check all applicable plans and provide a copy of all insurance cards, both front and back.

| | | | |
|---|---|---|---|
| ☐ **Medicare** Plan # | | ☐ **Other** | |
| ☐ **Medicaid** Plan # | | ☐ **Private** Insurance Carrier: | |
| Card # | Effective Date (mm/dd/year) / / | Insurance ID # | Insurance Group # |
| BIN: | PCN: | Insurance Phone Number: ( ) | |

## Responsible Party Information

| | | | |
|---|---|---|---|
| Responsible Party Name | | Relationship to Resident | |
| Responsible Party Address | City | State | Zip |
| Responsible Party Phone ( ) | Responsible Party Email | | |

## Agreement to Pharmacy Services and Financial Responsibility

I consent to receive pharmacy services and supplies from ValueMed ☐ Yes ☐ No

☐ Opt-Out: I do not wish to receive automatic monthly refills of my medications.

This agreement is entered into this day, between ValueMed ("Pharmacy") and the Resident and Responsible Party listed above who agree as follows:

1. The Pharmacy shall provide pharmacy services and supplies to the Resident on an open account and will provide the Responsible Party a listing of the medications supplied, and date of service.
2. The Resident and Responsible Party agree that they will be both individually and jointly responsible for paying to the Pharmacy any sums due for pharmacy services and supplies furnished to the Resident that are not reimbursed by outside sources, and the Responsible Party hereby guarantees that the pharmacy will be paid all sums due.
3. The Pharmacy will submit bills to the appropriate participating insurance plan or other reimbursement programs.
4. The Pharmacy will charge Resident or the Responsible Party for any co-payments and non-covered or un-reimbursed medications.
5. This Agreement shall bind the person or persons signed below. If signed by only the Responsible Party, it shall be binding on that party without regard to absence of the Resident's signature. If signed by only the Resident, the Resident shall be considered to be both the Resident and the Responsible Party for the purposes of this Agreement. Intending to be legally bound hereby, the Resident and Responsible Party have/has executed this Agreement providing for payment and guarantees of the sums due the Pharmacy for provision of pharmaceuticals and pharmacy services to the Resident on the date indicated below.

Resident or Responsible Party Signature Date (mm/dd/year) / /

**Fax completed form to: 1-855-879-2669**

Pacific

Customer Service: **1-888-588-1633**

**MyValueMed.com**

ValueMed

# Payment Authorization: Credit/Debit Card

Please complete and fax this form to **1-888-483-6117**. Payment authorization will remain in effect with ValueMed as long as you use ValueMed services.

## General Information

| | |
|---|---|
| Resident Name | Phone ( ) |
| Responsible Party Name | Relationship to Resident |
| Responsible Party Phone ( ) | Alternate Phone ( ) |
| Responsible Party Email | |

## Billing Address

| | | |
|---|---|---|
| Address | | |
| City | St | Zip |

## Credit/Debit Card Information

Cardholder Name

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Credit Card # Expiration Date (mm/year) / Security Code

☐ I authorize ValueMed to automatically charge the above credit/debit card each month for pharmacy services for the resident. ValueMed will send a monthly statement copy each month to review. I may discontinue this automatic monthly payment agreement at any time by calling ValueMed at 1-888-588-1633.

## Authorization

I authorize ValueMed to bill my account for pharmacy services. I may discontinue this agreement at any time by contacting ValueMed Customer Service. If your responsibility is less than $500 per individual prescription, ValueMed will send your medication. If your responsibility is greater than $500, ValueMed will call you to request authorization before processing.

Resident or Responsible Party Signature Date (mm/dd/year) / /

**Fax completed form to:**
**1-888-483-6117**

Customer Service: **1-888-588-1633**
**MyValueMed.com**

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