

Publix Pharmacy Direct Care

Acknowledgments and Authorizations for Assignment of Benefits and Use/Release of Medical Information

Patient Name _____

Phone # _____

Address _____

City _____

State _____

ZIP _____

YOUR MEDICARE NUMBER HERE

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Acknowledgments

- The Pharmacy provided me with a Notice of Privacy Practices that explains how the Pharmacy may use or disclose my medical information and also certain rights that I have regarding such information.
- I can request that the Pharmacy provide me with counseling regarding the dispensed medications and/or supplies by calling the following toll-free number: 1-800-PUBLIX-RX.
- Dispensed medications and/or supplies may contain information regarding their proper use and also warnings about problems that can occur with their use.
- The health care providers that prescribe the dispensed medications and/or supplies are solely responsible for the management of my drug therapy.
- I am responsible for payment to the Pharmacy for the dispensed medications and/or supplies. If I have insurance coverage for the dispensed medications and/or supplies and I want the Pharmacy to file an insurance claim on my behalf, I am responsible for providing the Pharmacy with accurate benefits information. The Pharmacy may choose not to accept an assignment of my insurance benefits and I may need to file my own insurance claim. If the Pharmacy accepts an assignment of my insurance benefits I may be responsible for any part of the unpaid claim. I am responsible for meeting any requirements for insurance coverage eligibility.

Authorizations

- I authorize the Pharmacy and/or its business associates to contact me with information about the dispensed medications and/or supplies including sending me prescription refill reminders.
- If the Pharmacy files an insurance claim for the dispensed medications and/or supplies on my behalf then I authorize an assignment of my insurance benefits under such claim to the Pharmacy.
- I authorize the Pharmacy to use and/or disclose such information about me, including any medical related information that I provide to the Pharmacy or that is created or received by the Pharmacy, that the Pharmacy reasonably determines is necessary to receive payment for its services, carry out my treatment or conduct its health care operations. This authorization includes disclosures to health plans, pharmacy benefit managers, claims processors, billing companies, interpreters and other persons involved in my treatment.

By signing below, I certify that the following statements are true:

- I am the patient or the patient's guardian/personal representative signing on behalf of the patient.
- I read, understand, and agree to all the statements on this form.

SIGN YOUR NAME HERE

TODAY'S DATE (Month/Day/Year)

Sign, date, and return the entire form promptly! In order for us to bill Medicare and/or other insurance for your medical supplies and/or medication(s), this form must be completed, signed, dated, and returned to us.

P U B L I X

P H A R M A C Y

D I R E C T C A R E SM