RxAdvantage
Patient Safety Through Innovation

PATIENT RESPONSIBILITY REQUEST

Fax to: (251) 625-6502 OR (866) 478-7909
Attn: Admissions & Billing Departments

The pharmacy has received a request for medication and/or item(s) that are not covered by any payer source associated with this resident/patient.

In order for the pharmacy to dispense this medication and/or item(s), a signature of patient and/or responsible party is required. By doing so, the patient/responsible party is accepting charges for the medication and/or item(s) listed.

MEDICATION CAN NOT BE DISPENSED UNTIL PAYMENT AUTHORIZATION HAS BEEN OBTAINED.

FACILITY: _____ Date: _____

Patient's Name: _____
Last First MI

Date of Birth: _____

Patient/Responsible Party Authorizing Agent's Name: _____

Patient/Responsible Party Authorizing Agent's Signature: _____

Date: _____
Reason for Denial: (Circle One)

OTC Medicaid HMO Coverage Terminated Refill Too Soon Pharmacy Not Contracted

Please note that all payment authorizations are good for the life of the prescription unless otherwise requested.

1. Medication / Item: _____ Qty:_____ $_____

RX #: _____ RX Date: _____

2. Medication / Item: _____ Qty:_____ $_____

RX #: _____ RX Date: _____

3. Medication / Item: _____ Qty:_____ $_____

RX #: _____ RX Date: _____

Total Cost _____

7101 Hwy. 90, Suite 300 • Daphne, Alabama 36526
Phone (251) 625-6100 • Fax (251) 625-6502 • Toll Free (877) 770-7923 • Toll Free Fax (866) 478-7909