Admn Agrmnt

RESIDENT WELCOME INFORMATION

M Chest Institutional Pharmacy Group, LLC ("MChest")

Dear Resident and/or Family Member:

Thank you for choosing MChest Pharmacy as your pharmacy service provider! The entire team here knows what an important role pharmacy services provides in caring for you or your loved one and we hope to take a few minutes to explain some of the services to you as well. While you may be used to working with a retail pharmacy in the past, MChest is very different from that experience, but yet very cost competitive as you will see. Here are a few of the services that are being provided and go above and beyond your typical retail pharmacy:

- 24 hours /7 days a week/ 365 days a year service
- Numerous deliveries a day at no charge to you
- Staff in-servicing and education
- Knowledgeable Billing Department to assist you in all aspects of pharmacy drug coverage
- Emergency medication systems "in-house" for prompt medication access

In order to establish an account with MChest Pharmacy, we will need the following information returned to us. Upon receipt of basic resident information and a copy of your prescription insurance cards (typically submitted by the facility staff) and prior to receiving the Pharmaceuticals Purchase Agreement, MChest Pharmacy will setup a temporary account for you that will be limited to $100 in total charges and these charges will be due upon receipt of your invoice at the end of each month. Once MChest has received all of your signed forms, your account credit limit will be increased to $1,000 and you will be setup with 30 day payment terms. This means your monthly invoice will be due 30 days after the invoice date.

COPY & SEND	**Resident Information** **Prescription Insurance Card(s)** **Medicare and/or Medicaid Card(s)**
SIGN & RETURN	**Pharmaceuticals Purchase Agreement**

Fax completed forms and copies of insurance cards to the pharmacy servicing Facility – see www.mchest.com for pharmacy fax numbers.

Please feel free to contact us at 855-MCHEST1 (855-624-3781) to speak with any of our pharmacies or our billing office if you have any questions or concerns. In addition, if you feel we do not have current or accurate insurance information, our billing department will gladly accept the information over the phone, by contacting us at 855-MCHEST1 (855-624-3781).

We thank you again for the opportunity to serve you or your family member!

Sincerely,
M Chest Pharmacy

RESIDENT INFORMATION

MChest Institutional Pharmacy Group, LLC ("MChest")

Resident's name: _____
(First) (Middle Initial) (Last)

Birth date: ____/____/_____ Social Security #_____ ☐ Male ☐ Female

Facility Name:_____

Primary Care Physician:_____ Phone #: _____

Medical Diagnosis:_____

Allergies: _____

Prescription Drug Insurance

It is very important for you to provide MChest with the latest **prescription insurance** information to enable accurate billing. Most prescription insurance cards have the following information listed below:

Rx Group
Rx BIN Rx PCN Cardholder ID

Prescription Insurance Card: ☐ Yes ☐ No

You MUST complete below information in order for MChest to file your insurance claims.

Prescription Insurance Plan:_____ Cardholder ID# _____

Rx Group#:_____ Rx BIN#: _____

Relationship to Cardholder: ☐ Self ☐ Spouse ☐ Other _____

You MUST provide a copy of FRONT and BACK of the following two items or we will not be able to process your insurance:

☐ Prescription insurance card (Front and Back copied)

☐ Medicare and/or Medicaid Card

_____ _____

(Name of person completing form) (Relationship to Resident)

Admn Agrmnt

PHARMACEUTICALS PURCHASE AGREEMENT

MChest Institutional Pharmacy Group, LLC ("MChest")
This is an agreement for pharmacy services with MChest

Resident Name (Please Print): _____

Resident's Date of Birth: _____ Soc. Sec. #: _____

Resident is solely responsible for financial and legal authorizations: ☐ Yes ☐ No

If answer above is NO, please list Guardian or person with Financial Power of Authority ("POA") below. A Guardian or Financial POA is a person who has been granted the authority in writing by either the Resident or a court of law to make medical and/or financial decisions on behalf of the Resident.

Guardian or Financial POA (If Different from Resident): _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Relationship to Resident/ Resident: _____Spouse _____Child _____Legal Dependent _____POA

Each month an itemized bill for pharmacy services not covered by insurance will be sent to you. This bill is payable directly to MChest upon receipt. If payment is not received by the next billing cycle, a 1.5% late fee (or a minimum $2.00 charge) will automatically be charged. MChest also accepts payment by credit card (If you wish to pay by credit card, complete and return the separate Credit Card Authorization Form).

Request for Services

I understand that by signing this agreement I indicate my wish to purchase health care products or services from MChest. I also understand that products provided by MChest will be dispensed in containers that are not child resistant. I request that the facility and/or MChest dispose of, or otherwise process, all unused and/or discontinued medications dispensed to me, according to the facility and pharmacy policy as allowed by professional standards and regulations.

Indication of Medical Responsibility

I understand that I am under the supervision and control of my attending physician. I also understand that my physician has prescribed the therapy, equipment and/ or supplies noted as part of my treatment. I understand MChest services do not include diagnostic, prescriptive or other functions typically performed by a licensed physician and that my physician is solely responsible for diagnosing and prescribing drugs and therapy for my condition, and supervising and controlling my medical care.

Assignment of Benefits

I authorize MChest to request on my behalf and collect all public and private insurance coverage benefits due for the products and services supplied to the Resident by MChest. In the event payment for insurance benefits is made directly to

any of the undersigned, the payee will endorse all checks for such payment to MChest. I hereby authorize MChest to submit a claim to my insurance carrier or its intermediaries for all covered prescriptions and authorize and direct my insurance carrier or its intermediaries to issue payment directly to MChest. I hereby authorize MChest to furnish complete information requested by my insurance carrier or its intermediaries regarding services rendered. I further agree that I am responsible for paying my co-pays or balances which remain after insurance payments have been made, including any cost of collection or legal fee incurred to collect these balances.

Release of Information

I authorize the insurer(s) and any other third party payor who provides the Resident with coverage to disclose to the MChest any information regarding such coverage, including but not limited to:

a. payment made by such insurer(s) or third party payor(s) to any of us, for the therapy rendered to the MChest; and

b. the scope and extent of coverage available from time to time. The Resident authorizes all medical personnel to provide information to MChest concerning his/ her medical history if it relates to the Resident's therapy.

I consent to the review of my records including medical records by any federal, state or accrediting body or agency as required by the regulatory, licensing or accrediting body.

Privacy Notice

I certify that I have had an opportunity to review MChest's Notice of Privacy Practices (available at www.mchest.com) and ask questions to assist me in understanding the rights relative to the protection of the above-named resident's health information. I am satisfied with the explanations provided to me and I am confident that MChest is committed to protecting my health information

Authorized Credit Limit Requested

Authorized Credit Limit: _____$1,000 or if less than $1,000 limit is desired, please enter amount below
_____$_____

SIGNATURE PAGE FOLLOWS

SIGNATURE PAGE – PHARMACEUTICALS PURCHASE AGREEMENT

In consideration of MChest undertaking to supply the Resident with any products and services ordered by the Resident or on behalf of the Resident, the undersigned Resident, spouse, guarantor and/ or guardian agrees that each is responsible to MChest for payment to MChest for all such products and services provided to the Resident, including the full amount of charges (plus any collection costs), if no payment is made for the claims submitted to the insurance company. Resident agrees to transfer immediately to MChest any payment made directly to me for services provided by MChest on an assigned basis.

The undersigned certifies that he/she is the Resident, or is authorized by the Resident as the Resident's general agent, to execute this Pharmaceutical Purchase Agreement and accept these terms. The undersigned certifies that the information furnished is true and correct and acknowledges that it is a crime to fill out this form with facts that are false or to leave out facts that are important. MChest may contact Resident, Guardian for Financial POA in the future, via telephone or other means of communication in regard to Resident's account with MChest.

Note: A duplicate copy of this Pharmaceutical Purchase Agreement shall be considered the same as the original.

Resident Printed Name:_____

Facility Name:_____

Resident Signature:_____ Date: _____

Guardian or Financial POA Signature:_____ Date: _____

Guardian or Financial POA Name (Please Print): _____

Billing Address: _____
Street

_____ _____ _____
City State Zip Code

Phone #:_____ ____Home#_____Work# ____Cell #

E-Mai Address: _____

A Guardian or Financial POA is a person who has been granted the authority in writing by either the Resident or a court of law to make medical and/or financial decisions on behalf of the Resident.