LTC SCRIPTS
A COMMUNICATION-FOCUSED pharmacy

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CUSTOMER SUPPLY AGREEMENT

RESIDENT INFORMATION:

NAME_____ROOM/apt#_____D.O.B._____

SOC.SEC:_____ALLERGIES:_____ Dx_____

HOME/COMMUNITY ADDRESS:_____

TELI#_____

INSURANCE INFORMATION (PLEASE ATTACH ALL INSURANCE CARDS):

INSURANCE COMPANY NAME:_____

ID NUMBER:_____GROUP#_____

TEL#_____

LTC SCRIPTS INC. PARTICIPATES IN MANY MANAGED CARE PRESCRIPTION PLANS. IN ORDER TO PROPERLY SUBMIT CLAIMS DIRECTLY TO YOUR INSURANCE CARRIER, WE MUST HAVE A **COPY OF** ALL CURRENT INSURANCE **CARDS/** INFORMATION PRESENTED/FAXED TO US BEFORE ANY SERVICES CAN BE PROVIDED. (MEDICAID AND ANY SECONDARY INSURANCE THIS INCLUDES MEDICARE, CARDS).

IN THE EVENT WE ARE UNABLE TO DIRECTLY BILL YOUR INSURANCE CARRIER; PAYMENT IS REQUIRED TO BE MADE BY THE PATIENT OR THE PATIENT'S REPRESENTATION. COPIES OF RECEIPTS OF PAYMENT WILL BE PROVIDED FOR YOUR REIMBURSEMENT CLAIM.

I AGREE TO USE LTC SCRIPTS INC. FOR ALL MEDICATION NEEDS & AUTHORIZE THEM TO BILL INSURANCES ON BEHALF OF ABOVE PATIENT. I FURTHER AGREE THAT I WILL BE RESPONSIBLE FOR ALL PHARMACY INVOICES NOT REIMBURSED BY INSURANCE FOR THE ABOVE PATIENT.

PERSONAL PAYMENT GUARANTY (RESPONSIBLE PARTY):

CHARGES FOR "OVER THE COUNTER", CO PAYS, DEDUCTIBLES AND ALL OTHER CHARGES WILL BE BILLED MONTHLY & ARE THE SOLE RESPONSIBILITY OF THE GUARANTOR BELOW. ALL PAYMENTS ARE DUE UPON PRESENTATION OF THE INVOICE FOR GOODS AND SERVICES PROVIDED. FINANCE CHARGES WILL ACCRUE AT 1.5% PER MONTH.

I,_____,personally and independently guarantee payment of the above listed charges promptly, as and when they become due as per this agreement.

SIGNATURE:_____DATE_____

ADDRESS_____CITY_____STATE_____ZIP_____

DAY TELEPHONE (____)_____EVENING TELEPHONE (___)_____

CREDIT CARD AUTHORIZATION (OPTIONAL PAYMENT BY CREDIT CARD)

(Complete only if you wish your credit card to be charged for the monthly charges)

CREDIT CARD NUMBER#_____

EXP DATE_____ CCV CODE(ON BACK):_____

CREDIT CARD AUTHORIZATION _____

Signature_____