KEYSTONE PROFESSIONAL PHARMACY Registration Form 2018-2019

PLEASE COMPLETE THIS FORM CLEARLY

Mail/Fax/Email this form with prescriptions, copy of both sides of
Prescription Insurance Card to:
Keystone Professional Pharmacy, 485 S. River Street, Wilkes-Barre, PA 18703

Student Last Name _____ Student First Name _____ Middle __

Student DOB _____ Male ____ Female ____ Medication Allergies _____

Parent/Legal Guardian Full Name _____

Address _____ City _____ State ____ Zip _____

Home Phone _____ Work _____ Cell _____ Email _____

Name of School _____ State Located _____

School Start Date _____ School End Date_____

Insured Name (subscriber) _____ DOB (subscriber) _____

Name of Prescription Plan _____ Phone _____

Member/ID# _____ **RxBin#** _____ **RxPCN#** _____ **RxGroup#** _____

Secondary insurance (if applicable) _____ Phone _____

Member/ID # _____ Rx Group#/RxBin/RxPcn _____ (if applicable)

List up to 3 different medications your student currently takes (this is only to assist in the insurance verification process - we do not use this for dispensing purpose)

_____

Credit Card # MC/VISA/DISC _____ Exp Date _____ CVV code____
Billing Address (if different from home address) _____
Full Name of Person on Credit Card _____

HAS/FSA credit card # (if applicable) _____ Exp Date _____ CVV code _____
Billing Address (if different from home address) _____
Full Name of Person on Credit Card _____

Please check the following items:
____ Enclosed is a copy of both sides of my Prescription Insurance Card
____ Enclosed are the original prescriptions

____ I am not submitting insurance for the medications. Charge my credit card for the medication.
____ I am aware that if no specific time is written on the physician prescription, my student's medication will be dispensed according to the school's dispensing times: breakfast, lunch, dinner, bedtime.
____ I am aware that all medications that are ordered for **only once a day** will be administered in the morning unless otherwise specified on the prescription.
____ I am aware that if **DAW (DISPENSE AS WRITTEN) OR BRAND** is not indicated, **GENERIC** medication will be dispensed.
____ Total # of Prescriptions Enclosed.

In signing below, I acknowledge that I am responsible for the cost of any medication not covered by my Medicaid/insurance company, for any medication the pharmacy cannot get reimbursed for or reimbursed their cost, as well as any co-payments and deductibles, which I agree will be billed directly to my credit card by the pharmacy. If I am submitting insurance information, I agree to authorize the pharmacy to contact my insurance company for insurance verification, billing and collections for my child's medications. Our licensed pharmacies are HIPAA compliant and all personal information received will be solely maintained for the purpose of dispensing medication and insurance collection. I acknowledge that I will pay_____.

Parent/Legal Guardian Signature _____

TO: KEYSTONE PROFESSIONAL PHARMACY STUDENTS

Keystone Pharmacy
485 S. River Street
Wilkes-Barre, PA 18703
Fax: 570-970-2205
NPI#: 1255443263

Please print this page and bring to the prescribing physician(s) so they will know where the prescription(s) should be sent.

If your physician still writes "paper" prescriptions, we accept those as well.

At the end of this registration, you will print a receipt. You may fax or scan and e-mail a copy of the receipt and the completed Medication List Form. Your hand written Medication List must match the prescriptions prescribed by the physician. If your physician issues electronic prescriptions, please make a note on the med list form "E-Scripts to follow".

The pharmacy contact is only for E-scripts. Any questions or concerns should be addressed directly to Keystone Pharmacy at 570-970-2200.

EMAIL ADDRESS: INFO@KPPMEDS.COM