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 St, 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_____

HSA/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 medicine will be dispensed according to the schools 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 delivery fees if above required items are not received 30 days prior to my student's start date.

Parent/Legal Guardian Signature_____

To: SchoolMed Families

If your student's physician is prescribing medication via electronic prescriptions, please provide the Physician with the following information for escribing directly to our SchoolMed Pharmacy Partner below:

This address is to be used by the physician only.

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 SchoolMed the copy of the receipt and the completed Medication List Form. Your hand written Medication List must match the prescriptions prescribed by the physician.
If you 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 or info@schoolmed.com

Thank you

IMPORTANT PLEASE READ

Dear School Parents,

On the next page you will be completing the medication form listing each of the prescriptions, OTC medications and supplements your student will be taking during school.

It is very important that you fill each column accurately.

We find a high amount of discrepancies between Parent's instruction on the written medication form and the way the prescription is written. Please make sure your medication form matches the prescriptions. During the physician visit, please re-confirm each detail, especially if the medication will be E-scribed.

The most common discrepancies are:

GENERIC vs BRAND
DAILY vs AS NEEDED
TIME OF THE DAY
EXAMPLE: AM, PM OR SPECIFIC TIME

Nasal sprays, inhalers, eye drops, etc. must have very specific instructions (Example: 2 puffs each nostril twice a day)

Please do not forget to date and sign the medication page.

If we are not able to clarify the discrepancies, the medication will be dispensed as written by the physician.

You can find more detailed instructions on the medication form.

IMPORTANT - MAIL THIS FORM TO KEYSTONE PHARMACY ALONG WITH REGISTRATION RECEIPT, PRESCRIPTIONS AND PRESCRIPTION COVERAGE CARD (if applicable)

Keystone Professional Pharmacy

485 S. River St., Wilkes-Barre, PA 18703 phone 570-970-2200 fax 570-970-2205

Student ID: _____(Keystone will assign)

Student Last Name: _____

Student First Name: _____

School Name: _____

Pharmacy Name: KEYSTONE PROFESSIONAL will be charging your credit card for all medication charges.

Start Date: _____

End Date: _____

LIST ALL PRESCRIPTION AND NON PRESCRIPTION MEDS TO BE DISPENSED BY SCHOOLMED.

Medication/Vitamins *Include RX and OTC	Strength or Dose ie: mg, ml, mcg	Medication Form tablet, capsule, liquid, chew		Dosing Instructions Time of day per dose	Daily or As Needed
1.					
2.					
3.					
4.					
5.					
6.					
7.					

This list MUST match the prescriptions sent to Keystone l. Prescriptions will be dispensed EXACTLY as written by the prescriber. Carefully review all written prescriptions to ensure they are IDENTICAL to your list above. If not, contact physician for new RX prior to sending to Keystone Professional Pharmacy.

Medication is dispensed as GENERIC unless the PRESCRIPTION clearly instructs "BRAND NAME NECESSARY". You may incur a higher co pay from your insurance carrier for the a brand name drug.

*** Over the Counter Meds ***
You do not need a prescription for Over the Counter medicine. the pharmacy will dispense your exact written request.

Medication prescribed to be taken DAILY will be administered in the MORNING unless written above and on the RX.

AS NEEDED medication will be refilled ONLY when requested by the school nurse.

I acknowledge that I am responsible for the cost of any medication not covered by my insurance company, for any medication the pharmacy cannot get reimbursed for, as well as any co-payments, deductibles, and charges for over the counter medicine which I authorize to be charged directly to my credit card by the : Keystone Pharmacy.
If I am submitting insurance information, I agree to authorize the Keystone Pharmacy to contact my insurance company for insurance verification, billing and collections for my student's medications. Our licensed pharmacies are HIPAA compliant and all personal information received will be solely maintained for the purpose of filling prescriptions and processing insurance claims. I understand and agree that I may receive emails from Keystone Pharmacy containing medication information regarding my student.

Signature Of Guarantor_____

Print Name_____ Date_____