***KEYSTONE PROFESSIONAL PHARMACY Registration Form*-2020-2021**

PLEASE COMPLETE THIS FORM CLEARLY

Mail/Fax/Email this form with prescriptions, copy of both sides of Prescription Insurance Card to:
Keystone Pharmacy 485 S River St, Wilkes-Barre, PA 18703; FAX 570-970-2205; EMAIL info@kppmeds.com

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 for, 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 a late fee of $25 and corresponding delivery fees if above required items are not received 30 days prior to my student's start date.

Parent/Legal Guardian Signature_____