Responsible Party Authorization for Pharmacy Services
Residential Care Facility
GPW-GPE-SO-LC

Facility Name: ______________________________ **Admit Date**: ______________________

Residents Name_________________________**SSN**_______________**DOB**____________

Doctor's Name: _________________________ **Phone No.**_________________________

Pharmacy Billing Status (Check all applicable types and attach copy(s) of card(s)

( ) **Private (Comments)** ____

( ) **Medi-Cal Member #**____

( ) **Other (Give Carrier Name, Group # & Member ID :)** _______________________________

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Responsible Party Information for Billing ( ) **Self**

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Daytime Phone (   ) ___________________________ **Evening Phone (   )**___________________

Please check and sign Only One box as it applies to the named resident's situation
I authorize Plaza Pharmacy to bill the above insurance for the named resident's medications. I accept liability for payment of:
( ) Medi-Cal formulator medications and non-covered drugs as ordered.
( ) Prescriptions co-payments and non-covered items as ordered.
( ) Medi-Cal formulary medications only.
( ) Emergency supplies and medications only.
( ) I am a private patient. I accept liability for the payment of medications for the named resident.

______________________________________ ____
Signature of Responsible Party Date