RESIDENT ENROLLMENT FORM

Saliba's Extended Care Pharmacy
A Guardian Pharmacy®

RETURN TO PHARMACY

RESIDENT INFORMATION

RESIDENT NAME _____
[FIRST] [MIDDLE INITIAL] [LAST]

SSN# _____-_____-_____ DOB _____/_____/_____ □ MALE □ FEMALE

COMMUNITY NAME _____ APT# _____

PRIMARY CARE PHYSICIAN _____ PHYSICIAN PHONE _____

MEDICAL DIAGNOSIS _____ ALLERGIES _____

PRESCRIPTION DRUG INSURANCE

PRESCRIPTION INSURANCE PLAN _____ CARDHOLDER ID# _____

RX GROUP# _____ RX BIN# _____ PCN# _____

RELATIONSHIP TO CARDHOLDER: □ SELF □ SPOUSE □ OTHER _____

**A PHOTO COPY OF THE INSURANCE CARD [FRONT AND BACK] MUST BE INCLUDED FOR THE PHARMACY TO PROCESS INSURANCE*

RESPONSIBLE PARTY INFORMATION

PRIMARY _____ RELATIONSHIP TO RESIDENT _____
[FIRST] [LAST]

PHONE _____ □ HOME □ CELL EMAIL _____

ADDRESS* _____
[STREET] [CITY] [STATE] [ZIP CODE]

**MONTHLY STATEMENTS WILL BE MAILED TO THIS ADDRESS*

SECONDARY* _____ RELATIONSHIP TO RESIDENT _____
[FIRST] [LAST]

PHONE _____ □ HOME □ CELL EMAIL _____

**SECONDARY MUST BE COMPLETED IF RESIDENT IS LISTED AS PRIMARY CONTACT*

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PAYMENT INFORMATION

TYPE OF CARD (circle): **VISA** **MASTERCARD** **AMERICAN EXPRESS** **DISCOVER**

NAME ON CARD: _____ **CARD NUMBER:** _____

BILLING ADDRESS: _____ **CITY, STATE, ZIP:** _____

SECURITY CODE: _____ **EXPIRATION DATE:** _____

*VISA/MC/DISCOVER: 3 digits on back of card
*AMEX: 4 digits on front of card

OR

ACCOUNT HOLDER NAME: _____

ACCOUNT ADDRESS: _____ **CITY, STATE, ZIP:** _____

BANK NAME: _____ **ROUTING #:** _____

CHECKING ACCOUNT #: _____

Please select an option below and sign.

☐ *I wish to pay automatically by credit card each month – please enroll me in auto-pay.*

☐ *I will mail in payment by check or call to pay by phone each month, promptly after receipt of Guardian's statement.*

*If payment is not received from resident within 60 days, Guardian will attempt to contact the responsible party. After which, if payment still has not been received, payment will be drafted from card on file. Credit card will only be used after Guardian notifies responsible party of non-payment of an outstanding balance. Guardian reserves the right to withhold services if payment is 90 days or more past due and no good faith effort has been made to bring the balance current. Payments that remain delinquent may be turned over to collections and reported to credit reporting agencies.

RESIDENT OR RESPONSIBLE PARTY SIGNATURE _____