University of Colorado
Anschutz Medical Campus
Hemophilia and Thrombosis Center

PATIENT AUTHORIZATION AND PLAN OF SERVICE

Insurance payment authorization: I request that Medicare and/or any other insurance plan that I have to make payments of authorized benefits on my behalf directly to The University of Colorado Hemophilia Center Pharmacy for pharmaceuticals / supplies that were furnished to me for which they bill you on my behalf.

Release of insurance information: I request my medical insurance plan(s) to release to the above named company, any and all information which will assist in processing my claims for medical supplies and/or equipment that I am receiving from the above named company even after service to me is discontinued. I also authorized any holder of hospital or medical information about me to release to the health care financing administration, its agents, my insurance company or the above named company any information needed to determine the benefits that are payable for related services.

I understand if my insurance plan(s) makes payment(s) to me for medications, services and supplies that I have received, rather than directly to the above named company, I agree to endorse those checks and send them immediately to the above named company.

I also understand that I am responsible for the payment of any deductible, co-insurance or other portion of my charges not paid by my insurance plan(s). I also understand that I may be eligible for a partial or complete waiver of any unpaid co-insurance charges only, under The University of Colorado Hemophilia Center Pharmacy financial hardship program.

_____ (Initials) I acknowledge that I have been advised of my financial obligations to The University of Colorado Hemophilia Center Pharmacy including copays, deductibles and any anticipated denials for products furnished by The University of Colorado Hemophilia Center Pharmacy.

_____ (Initials) I acknowledge that I have received a copy of the HIPAA PRIVACY NOTICE

I hereby agree that The University of Colorado Hemophilia Center Pharmacy or any of its affiliates may contact me, or my authorized caregiver, by telephone at my place of residence.

I have reviewed and understand the information above. I have been instructed on and understand the use of the products provided. I have received the products ordered. I have received a copy of a patient handout that contains a welcome letter, patient rights and responsibilities, privacy standards, emergency planning, making decisions about your health care, grievance/complaint information and drug disposal techniques. I have received the product manual/instructions, warranty information, and instructions to follow up with The University of Colorado Hemophilia Center Pharmacy.

I understand that prescribed medications cannot be re-dispensed. Therefore, these items cannot be returned for credit.

I understand that I may lodge a complaint without concern for reprisal, discrimination, or unreasonable interruption of service.

Identified needs/problems: The patient may be unfamiliar with use of the medications and product(s) provided. Expected outcomes: The patient will be provided the medications and product(s) to comply with the physician's prescription. The patient will use the medications and product(s) as prescribed by the physician. The patient will know how to obtain follow-up services as needed.

PATIENT NAME:_____

PATIENT OR RESPONSIBLE PARTY (IF UNDER 18 YEARS OF AGE)

PRINT NAME: _____

PATIENT OR RESPONSIBLE PARTY SIGNATURE: X_____DATE:____/____/____

IF BENEFICIARY IS UNABLE TO SIGN:_____

WITNESS SIGNATURE / RELATIONSHIP:_____

REASON PATIENT UNABLE TO SIGN:_____

Please return the Patient Authorization and Plan of Service Form to The University of Colorado Hemophilia Center Pharmacy in the envelope provided. Thank you for choosing The University of Colorado Hemophilia Center Pharmacy.