Outpatient Intake Form

Patient Information

Patient Last Name (Please Print)	First Name	Middle Initial

Date of Birth:	Gender: ◯ M ◯ F	Social Security Number:	Medicare ID:

Address:	When do you need us to start:	Current Pharmacies:

RxBin:	PCN:	Group:	ID:

Allergies:

Primary Caregiver:	Specialty Doctors:

Filling Frequency: □Request as Needed □Monthly □ Bi-Weekly □Weekly	Requested Packaging: □Bottles □Dispill Packaging (Multi-Med) □Individual Bubble Packs

Please include a copy of insurance card (both sides) if possible.

Payee Information

Patient Name:		Date of Birth:	
Payee Name:		Relationship:	
Address:	City:	State:	Zip Code:
Home Phone Number:		Alternate Phone Number:	
Emergency Contact:		Emergency Phone Number:	

Are there meds to repackage? ☐ YES ☐ NO

I am requesting an existing supply of medications, either for myself or my family member, to be repackaged by Big Sky Managed Care. I understand Big Sky Managed Care will only repack a prescription medication until it can be billed to insurance. Once insurance can be billed, prescription medications will be supplied by Big Sky Managed Care. Over-the-counter (OTC) items and controlled medications will not be repackaged by Big Sky Managed Care, except at the discretion of the pharmacist and/or supervisor. Big Sky Managed Care reserves the right to refuse to repackage any medication if the pharmacist feels that doing so poses a risk to the patient (ex: the pharmacist is unable to identify the product or its integrity.)

Once Big Sky Managed Care begins supplying medications for myself or my family member, unused medications will be destroyed.

I acknowledge the above statement. _____ _____

Signature Date

Privacy Notice

I certify that I have received a copy of the privacy notice (HIPPA) and have reviewed the document. I acknowledge that Big Sky Managed Care, LLC is committed to protecting my health information.

Signature:_____Printed Name:_____
Date:_____

I understand that I am financially responsible to Big Sky Managed Care, LLC. for all charges incurred by the above-named patient, including copays, collection fees, etc. All non-covered medications and supplies will be billed to the patient or responsible party, unless prohibited by state regulations. All statement balances shall be paid in full unless other arrangements are made.

Patient or Responsible Party: _____Date:_____

I request that all medications, now and in the future, be dispensed in a non-child resistant container.

Resident or Responsible Party: _____ Date:_____

Re-packaging Waiver of Liability: I understand that I am requesting Big Sky Managed Care to repackage my medications from their original containers into a multi-dose packaging system. Big Sky Managed Care reserves the right to repack medications when the manufacturer's guidelines recommend otherwise.

Patient Name _____ Signature _____

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Card Type: MasterCard__ Visa__ Discover__ AMEX__ Other_____

Cardholder Name: (as shown on card)	**Card Number:**
Expiration Date: (mm/yy)	**Billing Zip Code:**
CVV:	

I _____, authorize Big Sky Managed Care to charge my credit card above on the first of every month for medications packaged for the above-named patient. I understand my information will be saved to file for future transactions on my account.

Payee Signature:	**Date:**

BIG SKY MANAGED CARE Rx

Montana Owned and Operated.

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