McElroy Pharmacy
100 E Main St
Lititz, PA 17543-2010

RECEIPT OF GOODS AND SERVICES

Beneficiary Name

Address

Product(s)

Consumable Refill Request
Date of Refill Request ____________________

Method of Request
Phone ________ In-Person ________
Staff Contact ________
Individual Requesting Refill ____________________

Beneficiary: Yes/No
Relationship to Beneficiary: ____________________

Staff Member ____________________
Est. Qty Remaining ______________

ACKNOWLEDGEMENTS: I acknowledge that I have been provided a copy of the facility's HIPAA Notice of Privacy Practices, Medicare DMEPOS Supplier Standards, Patient Bill of Rights and Responsibilities, patient complaint form and patient satisfaction survey. You may contact me concerning the furnishing of a Medicare-covered item that is to be rented or purchased. My signature acknowledges receipt & authorization.

ASSIGNMENT: I understand that the Centers for Medicare and Medicaid Services are the U.S. Government's Medicare agency. I understand that a photocopy of this release/assignment is valid as the original document and will remain in effect until revoked by me in writing. I understand that I am responsible for paying any deductible or co-pay amounts. I request that payment of authorized Medigap benefits be made either to me or on my behalf to McElroy Pharmacy for any items or services furnished me by that provider. I authorize any holder of medical information about me to release any covered entity, the Centers for Medicare and Medicaid Services (CMS), insurance company(s), and/or healthcare provider any information needed to determine these benefits or the benefits payable to related services.

EDUCATION: My signature below acknowledges that I and/or my caregiver have received education and demonstrated proper equipment usage. I have also received notice of warranty information. I understand that if I have additional questions and/or concerns with dispensed equipment, I should contact this facility at 717-626-2222.

WARRANTY: Every product sold or rented carries a manufacturer's warranty. This facility will notify all Medicare beneficiaries of the warranty coverage and we will honor all warranties under applicable law. In the event of a manufacturer defect, product recall, warranty repairs, substandard product or improperly fitted item, return the product and we will repair or replace, free of charge, Medicare-covered equipment that is under warranty. In addition, an owner's manual with warranty information will be provided to beneficiaries for all durable medical equipment where this manual is available.

PAYMENT: I request that payment of authorized insurance benefits, Medigap benefits and Medicare, if I am a Medicare beneficiary, be made on my behalf to McElroy Pharmacy for any services furnished me by that supplier.

FINANCIAL RESPONSIBILITY: I understand that I am financially responsible to McElroy Pharmacy for any charges not covered by health care benefits. It is my responsibility to notify this facility of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products received.

Proof of Delivery

Beneficiary Signature ____________________ by ____________________ *Authorized Representative [if applicable] ____________ Date

Employee Signature ____________________ ____________ Date

***If Authorized Representative signs on behalf of beneficiary, include the following:**

Authorized Representative Printed Name ____________________

Address of Authorized Representative ____________________

Relationship to Beneficiary ____________________

Reason Beneficiary Cannot Sign:
☐ Physically Unable ☐ Mentally Unable

- Product / Equipment Information -

Make	Model	Serial #	Lot #	Expiration Date
Make	Model	Serial #	Lot #	Expiration Date
Make	Model	Serial #	Lot #	Expiration Date

Monies Received

☐ Store Charge ☐ Credit/Debit Card ☐ Cash ☐ Check Received Check # Amount $

RJH Form F0317 (09/13/2008 – Rev. 01/2015)