COR

Care Options Rx

Specialists in Comprehensive Pharmacy Services

Efficient and convenient
Pharmacy Solutions,
designed to meet your needs.

219 N. Baltimore Avenue
Mt. Holly Springs, PA 17065
800-266-9954
Fax: 800-266-9947
www.careoptionsrx.com

Contents

*These pages need to be filled out completely and returned to Care Options Rx.

Pages 6,7 and 8 are required to be on file at the pharmacy. Please fill out pages 6,7 and 8 completely and return to Care Options Rx.

On Page 8, you may designate to whom you would like us to release information. If you have a power of attorney, this would also be a good time to provide the pharmacy with a copy of that designation.

Page 10, may be used any time you or your power of attorney need any medical records or health information. All requests must be in writing. (i.e. you require a medical expense summary for tax purposes)

For NEW Residents only:
Please supply a copy of the front and back of all prescription insurance cards. This will enable Care Options Rx to properly bill for your medications at the onset of service.

We, at Care Options Rx, look forward to developing a relationship with you and your family member(s). Your satisfaction is our goal, and we are here to answer any questions that you might have.

For questions by phone: **(717) 486-8606 or toll-free (800) 266-9954**

General questions: **mail2@CareOptionsRx.com**

Efficient and convenient **Pharmacy Solutions**, designed to meet your needs.

24/7 Availability

Around the clock support when you need us.

Packaging Options

Adherence based & traditional systems available, with customizable quantities.

Deliveries

Routine and urgent need deliveries; 7 days a week.

Cost Containment

Competitive pricing, paired with a strategic approach to reimbursement optimization.

Storage

Clean, customizable and secure carts & cabinets.

Support Services

Dedicated Account Management services, paired with clinical Nursing and Consultant Pharmacist support.

Technology

State-of-the-art dispensing technology, web-based offerings, and eMAR/eMR integration.

Compounding Services

Sterile and Non-Sterile, IV and topical preparations available.

COR
Care Options Rx

www.careoptionsrx.com

Billing Information

Cycle Fill

Care Options Rx supplies most medications using a method called "cycle fill". Most routine medications are automatically refilled and delivered on a specified cycle. Care Options Rx does not cycle fill liquid medications, inhalation medications, controlled substances, warfarin, medications that are taken on an "as needed" (PRN) basis, and/or Medicare Part B billable items (test strips, lancets, nebulizer machines and supplies, ostomy supplies). If a new medication is added in the middle of the cycle, Care Options Rx will fill the order for only enough doses to complete the current cycle. Thereafter, it will be refilled for the regular amount of days for the specified cycle.

Statements

Billing statements are run monthly on the 2nd business day of the following month. These statements are mailed to the designated financial responsible party that is indicated on the Release of Information form (included in the booklet) or sent directly to the community business office if no responsible party is indicated. The due date for each statement is the 24th of the month that they were printed.

Payment Options*

Payments can be made several ways for your convenience.

- ACH Draft from Checking or Savings

You can authorize Care Options Rx to automatically draft your monthly pharmacy bill from a checking or savings account.

- Credit Card/ Debit Card

- *On Demand Charge,* Call or mail a credit card payment monthly.
- *Monthly Automatic Charge*, Care Options Rx can securely store a credit/debit card for you and automatically charge that card for your pharmacy statement every month.

Turn your statement over for an area to write in your card information and for the option to make it a recurring monthly charge.

- Check

Checks can be sent to Care Options Rx monthly.

***With all of these options, you will still receive a monthly itemized billing statement.**

All pharmacy payments are made directly to Care Options Rx and can be made by phone or by mail.

There is a $30.00 fee for all returned checks or transactions involving non-sufficient funds or a closed account, etc.

Pharmacy Supplier Standards

Note: This is an abbreviated version of the supplier standards every Medicare DMEPOS supplier must meet in order to retain their billing privileges. These standards, in their entirety, are listed in 42 C.F.R. 424.57(c).

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. A supplier must have an authorized individual (whose signature is binding) sign the enrollment application for billing privileges.
4. A supplier must fill orders from its own inventory, or contact with other companies for the purchase of items necessary to fill orders. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or any other Federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site and must maintain a visible sign with posted hours of operation. The location must be accessible to the public and staffed during hours of business. The location must be at least 200 square feet and contain space for storing records.
8. A supplier must permit CMS or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service, or cell phone during posted business hours is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.
11. A supplier is prohibited from direct solicitation to Medicare beneficiaries. For complete details on this prohibition see 42 CFR § 424.58 (c) (11).
12. A supplier is responsible for delivery of and must instruct beneficiaries on the use of Medicare covered items, and maintain proof of delivery and beneficiary instruction.
13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair cost either directly or through a service contract with another company, any Medicare-covered items it has rented to beneficiaries.
15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these standards to each beneficiary it supplies a Medicare-covered item.
17. A supplier must disclose any person having ownership, financial, or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its Medicare billing number.
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of the complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number, and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and regulations.
22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services (except for certain exempt pharmaceuticals).
23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
26. A supplier must meet the surety bond requirements specified in 42 CFR § 424.57 (d).
27. A supplier must obtain oxygen from a state-licensed oxygen provider.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 CFR § 424.516 (f).
29. A supplier is prohibited from sharing a practice location with other Medicare providers and suppliers.
30. A supplier must remain open to the public for a minimum of 30 hours per week except physicians (as defined in section 1848(j) (3) of the Act) or physical and occupational therapists or a DMEPOS supplier working with custom made orthotics and prostetics.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

COR Care Options Rx

As part of the federal Health Insurance Portability and Accountability Act of 1996, known as HIPAA, the Facility has created this Notice of Privacy Practices (Notice). This Notice describes the Facility's privacy practices and the rights you, the individual, have as they relate to the privacy of your Protected Health Information (PHI). Your PHI is information about you, or that could be used to identify you, as it relates to your past and present physical and mental health care services. The HIPAA regulations require that the Facility protect the privacy of your PHI that the Facility has received or created.

This Facility will abide by the terms presented within this Notice. For any uses or disclosures that are not listed below (Including Marketing and Selling of PHI), the Facility will obtain a written authorization from you for that use or disclosure, which you will have the right to revoke at any time, as explained in more detail below. **The Facility reserves the right to change the Facility's privacy practices and this Notice.**

HOW THE FACILITY MAY USE AND DISCLOSE YOUR PHI

The following is an accounting of the ways that the Facility is permitted, by law, to use and disclose your PHI.

Uses and disclosures of PHI for Treatment: We will use the PHI that we receive from you to fill your prescription and coordinate or manage your health care.

Uses and disclosures of PHI for Payment: The Facility will disclose your PHI to obtain payment or reimbursement from insurers for your health care services.

Uses and disclosures of PHI for Health Care Operations: The Facility may use the minimum necessary amount of your PHI to conduct quality assessments, improvement activities, and evaluate the Facility workforce.

The following is an accounting of additional ways in which the Facility is permitted or required to use or disclose PHI about you without your written authorization.

Uses and disclosures as required by law: The Facility is required to use or disclose PHI about you as required and as limited by law.

Uses and disclosure for Public Health Activities: The Facility may use or disclose PHI about you to a public health authority that is authorized by law to collect for the purpose of preventing or controlling disease, injury, or disability. This includes the FDA so that it may monitor any adverse effects of drugs, foods, nutritional supplements and other products as required by law.

Uses and disclosure about victims of abuse, neglect or domestic violence: The Facility may use or disclose PHI about you to a government authority if it is reasonably believed you are a victim of abuse, neglect or domestic violence.

Uses and disclosures for health oversight activities: The Facility may use or disclose PHI about you to a health oversight agency for oversight activities which may include audits, investigations, inspections as necessary for licensure, compliance with civil laws, or other activities the health oversight agency is authorized by law to conduct.

Disclosures to Individuals Involved in your Care: The Facility may disclose PHI about you to individuals involved in your care. Disclosures for judicial and administrative proceedings: The Facility may disclose PHI about you in the course of any judicial or administrative proceedings, provided that proper documentation is presented to the Facility.

Disclosures for law enforcement purposes: The Facility may disclose PHI about you to law enforcement officials for authorized purposes as required by law or in response to a court order or subpoena.

Uses and disclosures about the deceased: The Facility may disclose PHI about a deceased, or prior to, and in reasonable anticipation of an individual's death, to coroners, medical examiners, and funeral directors.

Uses and disclosures for cadaveric organ, eye or tissue donation purposes: The Facility may use and disclose PHI for the purpose of procurement, banking, or transplantation of cadaveric organs, eyes, or tissues for donation purposes.

Uses and disclosures for research purposes: The Facility may use and disclose PHI about you for research purposes with a valid waiver of authorization approved by an institutional review board or a privacy board. Otherwise, the Facility will request a signed authorization by the individual for all other research purposes.

Uses and disclosures to avert a serious threat to health or safety: The Facility may use or disclose PHI about you, if it believed in good faith, and is consistent with any applicable law and standards of ethical conduct, to avert a serious threat to health or safety.

Uses and disclosures for specialized government functions: The Facility may use or disclose PHI about you for specialized government functions including; military and veteran's activities, national security and intelligence, protective services, department of state functions, and correctional institutions and law enforcement custodial situations.

Disclosure for workers' compensation: The Facility may disclose PHI about you as authorized by and to the extent necessary to comply with workers' compensation laws or programs established by law.

Disclosures for disaster relief purposes: The Facility may disclose PHI about you as authorized by law to a public or private entity to assist in disaster relief efforts and for family and personal representative notification.

Disclosures to business associates: The Facility may disclose PHI about you to the Facility's business associates for services that they may provide to or for the Facility to assist the Facility to provide quality health care. To ensure the privacy of your PHI, we require all business associates to apply appropriate safeguards to any PHI they receive or create.

OTHER USES AND DISCLOSURES

The Facility may contact you for the following purposes:

Information about treatment alternatives: The Facility may contact you to notify you of alternative treatments and/or products.

Health related benefits or services: The Facility may use your PHI to notify you of benefits and services the Facility provides.

Fundraising: If the Facility participates in a fundraising activity, the Facility may use demographic PHI to send you a fundraising packet, or the Facility may disclose demographic PHI about you to its business associate or an institutionally related foundation to send you a fundraising packet. No further disclosure will be allowed by the business associates or an institutionally related foundation without your written authorization. You will be provided with an opportunity to opt-out of all future fundraising activities.

FOR ALL OTHER USES AND DISCLOSURES

The Facility will obtain a written authorization from you for all other uses and disclosures of PHI, and the Facility will only use or disclose pursuant to such an authorization. In addition, you may revoke such an authorization in writing at any time. To revoke a previously authorized use or disclosure, please contact Care Options Rx to obtain a Request for Restriction of Uses and Disclosures.

YOUR HEALTH INFORMATION RIGHTS

The following are a list of your rights in respect to your PHI. Please contact Care Options Rx for more information about the below.

Request restrictions on certain uses and disclosures of your PHI: You have the right to request additional restrictions of the Facility's uses and disclosures of your PHI; however, the Facility is not required to accommodate a request. This includes the right to restrict disclosures to Insurances for those products and services you pay out-of-pocket for.

The right to have your PHI communicated to you by alternate means or locations: You have the right to request that the Facility communicate confidentially with you using an address or phone number other than your residence. However, state and federal laws require the Facility to have an accurate address and home phone number in case of emergencies. The Facility will consider all reasonable requests.

The right to inspect and/or obtain a copy your PHI: You have the right to request access and/or obtain a copy of your PHI that is contained in the Facility for the duration the Facility maintains PHI about you. There may be a reasonable cost-based charge for photocopying documents. You will be notified in advance of incurring such charges, if any.

The right to amend your PHI: You have the right to request an amendment of the PHI the Facility maintains about you, if you feel that the PHI the Facility has maintained about you is incorrect or otherwise incomplete. Under certain circumstances we may deny your request for amendment. If we do deny the request, you will have the right to have the denial reviewed by someone we designate who was not involved in the initial review. You may also ask the Secretary, United States Department of Health and Human Services ("HHS"), or their appropriate designee, to review such a denial.

The right to receive an accounting of disclosures of your PHI: You have the right to receive an accounting of certain disclosures of your PHI made by the Facility.

The right to receive additional copies of the Facility's Notice of Privacy Practices: You have the right to receive additional paper copies of this Notice, upon request, even if you initially agreed to receive the Notice electronically.

Notification of Breaches: You will be notified of any breaches that have compromised the privacy of your PHI.

REVISIONS TO THE NOTICE OF PRIVACY PRACTICES

The Facility reserves the right to change and/or revise this Notice and make the new revised version applicable to all PHI received prior to its effective date. The Facility will also post the revised version of the Notice in the Facility.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Facility and/or to the Secretary of HHS, or his designee. If you wish to file a complaint with the Facility, please contact Care Options Rx, If you wish to file a complaint with the Secretary, please write to:

http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html

The Facility will not take any adverse action against you as a result of your filing of a complaint.

CONTACT INFORMATION

If you have any questions on the Facility's privacy practices or for clarification on anything contained within the Notice, please contact:

Care Options Rx
219 N. Baltimore Avenue
Mt Holly Springs, PA 17065
(800) 266-9954

Resident Move-In Record and Agreement

Care Options Rx

Community Name _____ Move-In Date ____/____/____

Room/Unit# _____ Bed# _____

RESIDENT INFORMATION

First Name:_____ Last Name:_____ MI:_____

SS#:_____ Date of Birth:_____/_____/_____ Sex: ☐ M ☐ F

Medicare (HICN)#:_____ Phone:_____

Physician's Name:_____ Email:_____

Resident is solely responsible for the legal and financial authorizations: ☐ YES ☐ NO
If NO, please list the legal representative below:

First Name:_____ Last Name:_____

Relationship to resident:_____

Address: _____

City: _____ State:_____ Zip:_____

Phone:_____ Email:_____

A Legal Representative is a person who has been granted the authority in writing by either the Resident or a court of law to make medical and/or financial decisions on behalf of the Resident.

PRIMARY CONTACT & FINANCIALLY RESPONSIBLE PARTY INFORMATION

First Name:_____ Last Name:_____ MI:_____

Relationship to resident:_____

Address: _____

City: _____ State:_____ Zip:_____

Phone:_____ Email:_____

Primary contact is also Financially Responsible Party: ☐ YES ☐ NO
If NO, please list the Financially Responsible Party below:

First Name:_____ Last Name:_____ MI:_____

Relationship to resident:_____

Address: _____

City: _____ State:_____ Zip:_____

Phone:_____ Email:_____

A Financially Responsible Party is a person, other than the Resident, who agrees to be responsible for payment of all amounts owed by the Resident for products and services provided to the Resident.

Resident Move-In Record and Agreement cont.

Care Options Rx

NON-COVERED MEDICATION

Please indicate the preferred method for handling medications not covered by insurance.

☐ Dispense all medications (Prescription and over-the-counter, whether covered by insurance or not.)
☐ Dispense all covered medications and send a seven-day supply or smallest package size.
☐ Only dispense medications covered by insurance.*
*Items not covered by insurance will not be dispensed.

PAYMENT SOURCES FOR PHARMACY PRODUCTS AND SERVICES

To assist in billing for medications and services provided to the patient while at this community, please check all pay sources that apply:

☐ Medicare (Medicare effective date: _____/_____/_____)
☐ No Prescription insurance
☐ Medicare Part D: Plan Name:_____ Member ID#_____

Group#:_____ BIN/PNC#_____

☐ Medicade#:_____ State:_____ Effctive date:_____/_____/_____

☐ Other Insurance:_____ Number:_____ Phone:_____

☐ Hospice:_____ Hospice Phone:_____

☐ Veteran Drug Benefit

Please provide pharmacy with copies (front and back) of ALL Drug Coverage Cards.

AUTHORIZATION FOR PAYMENTS

☐ **Credit Card** ☐ Authorize Continuous Withdrawal, Monthly
☐ VISA ☐ Mastercard ☐ Discover ☐ American Express

CC#_____ Exp._____ CIV code: _____

Name as it appears on card:_____

☐ **Bank account transfer** Bank Name:_____

City:_____ State:_____ Zip: _____

Account#:_____ Routing#:_____

Assignment of Benefits: I assign the right and responsibility to Care Options Rx, to bill on my behalf and accept payment for Medicare services provided to me, the Beneficiary. I understand that I am responsible to pay any deductible amount applied to the claims and the coinsurance, or approved charge for a product or service. I permit Care Options Rx to release and collect my health information and other information, as required (and as permitted by the HIPAA Regulations) from my health care providers and insurance provider to receive payment from my insurance coverage. I understand that this form will be maintained and made available to my insurance provider or its representatives. Privacy Acknowledgement: I acknowledge that I have received a copy of the facility's Notice of Privacy Practices (included within this packet). this notice describes how medical information about you may be used and disclosed and how you can get access to this information.

By signing below, the Resident or their Legal Representative and the Financially Responsible Party acknowledge and agree to each of the terms described within this document.

Resident/Resident's Representative Name (please print) Signature Date

Financially Responsible Party Name (please print) Signature Date

NOTE: If Resident has **personally signed**, it is not necessary to complete the information below. If the Resident is physically unable to sign, an authorized Representative may sign on his/her behalf, but must complete all information, including the Resident's medical reason for an inability to sign.

Permission For Release of Information

Resident Name	Date of Birth
Address	Telephone#

Please mark the records you are allowing access to:

☐ Patient File (Demographic Information)
☐ Insurance Data
☐ Prescription Profile
☐ Payment Information
☐ Medical Expense Summary (MES)
☐ Other:_____

Effective April 14, 2003, the pharmacy will retain PHI/records and associated documents for ten (10) years from the date of last action.

I am requesting that the following individuals have access to my Protected Health Information (PHI) and medical records:

Primary (Power of Attorney)	***Secondary***	***Who should receive the monthly pharmacy statements?***
Name	Name	☐ Resident
Address	Address	☐ Primary/POA
Phone	Phone	☐ Secondary
E-mail	E-mail	

I understand that by signing below, I am giving the above listed individuals access to all of my protected health information and Care Options Rx may discuss that information with them.

Date	Signature of Individual/ Legal Representative	Legal Representative's Authority (Relationship to Individual)

You may Fax the completed form to 800-266-9947 or Mail it to:

Care Options Rx
219 N. Baltimore Avenue, Mt Holly Springs, PA 17065

Office Use Only - Please Do Not Write In This Space Date Rec'd_____ Initials_____

Questions and Concerns

Date _____ Time _____

Resident/ Responsible Party Name _____

Resident/ Responsible Party Phone _____

Questions/Concerns _____

You may fax this form to 800-266-9947 or mail it to:
Care Options Rx
219 N. Baltimore Avenue
Mt Holly Springs, PA 17065

☐ Resolved Resident/ Responsible Party's questions/concerns satisfactorily.
Response recorded below. No follow up necessary.

☐ Response requires professional judgment. Forwarded questions/concerns to:

_____
Pharmacy Personnel Name Date

☐ Research required. *(Attach research documentation, if any.)*

☐ Resident/ Responsible Party informed answer shall be provided by _____.
Date/Time

Response provided to Resident/ Responsible Party as follows:

_____

_____

_____

Answer provided to:

_____
Resident/ Responsible Party Name (Print) Date/Time of Call

_____
Pharmacy Representative Signature

Requset to Access Records

Resident Name	Date of Birth
Address	Telephone#

Must be completed for each patient.

☐ I would like a Medication Expense Report for the following years: _____

☐ Please describe the information you wish to have access to and in what format (we will try to comply with the format if possible.)

_____

_____

_____

I am requesting data from the following time frame (you may be able to go back six (6) years.

Start Date:_____ End Date:_____

If the records are being requested for a spouse or a child that is above the Age of Medical Consent, they will be mailed directly to the patient.

I understand that if the Facility grants access to records, they will provide the requested records within thirty (30) days or sixty (60) days if the records are maintained off-site from the receipt of the request. Also, I understand there may be a cost-based fee charged to process this request and the Facility will contact me prior to continuing action on this request for my acceptance of the fee amount (if any). If the Facility needs additional time, then the Facility's Privacy Officer will notify me with the reason. If the records are being requested for a spouse or a child that is above the Age of Medical Consent, they will be mailed directly to the patient.

If access to records is granted, I would like my requested records:

☐ Mailed to the address listed above. ☐ Sent in delivery tote with regular pharmacy delivery.

☐ Mailed to the address listed here:_____

☐ Available for pickup at the pharmacy. ☐ Emailed to:_____

_____ / / _____

Signature of Patient/Legal Guardian/Personal Representative | Relationship to Patient | Date

You may Fax the completed form to 800-266-9947 or Mail it to:

Care Options Rx
219 N. Baltimore Avenue, Mt Holly Springs, PA 17065

friendly

personalized service

money-saving

competitive prices

convenient

FREE local delivery