



Phone: 320-230-1050 - Fax: 855-502-1051

New Admission Cover Sheet

To: Guardian Pharmacy

From: _____

Fax#: 855-502-1051

Date: _____

Total no. of pages, including cover: _____

_____ **New Admit** _____ **Re-Admit (Hospital Return)**

Patient Name: _____ DOB: ____/____/____ Room #: _____

Patient Allergies: _____

Patient SS#: _____ Medicare #: _____

Primary Physician _____

Billing Information

*****Copy of insurance cards (front & back) must be sent to the pharmacy*****

_____ Facility Responsibility (Medicare A, MSHO...)

_____ Private Insurance (Medicare D, Medicaid...)

_____ Private Pay- Patient does not have any prescription drug coverage. **Page 2 must be completed.**

Responsible Party Name _____ Relationship _____

Responsible Party Address _____

Phone Number _____

Please remember to fax a copy of the PATIENTS FACE SHEET along with any copies of CONTROLLED SUBSTANCE PRESCRIPTIONS.

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