Memorial Specialty Pharmacy

Service Acknowledgement

Please sign and return to Memorial Specialty Pharmacy Services in the prepaid envelope provided

SHIPPING ACKNOWLEDGEMENT

To ensure effectiveness and delivery of your Specialty Medication at the highest quality standard, Memorial Specialty Pharmacy Services uses special packaging and expedited shipping.

Your medication will be shipped at no charge to you. We use an overnight national courier or a same-day local courier depending on the nature of the delivery, location and predetermined guidelines.

We will coordinate with you the exact date of delivery and the approximate time. Most deliveries will require signature by the recipient. Please ensure that you are home to sign and receive the package at its scheduled delivery location and time to avoid delay or compromising your medication.

In the event that you authorize your package to be delivered without a signature, please be advised that you are responsible for any lost, damaged or stolen packages.

In the event of a delivery delay, we will notify you of the reason for the delay. If a delay in a delivery results in interruption in your therapy, we will assist in facilitating a specialty medication fill from another pharmacy.

We value our customers and want to continue to provide excellent customer service. You can help us by verifying the accuracy of your shipments upon receipt. Please call your Memorial Specialty Pharmacy Services team to report any concerns or discrepancies.

WELCOME PACKET RECEIPT ACKNOWLEDGEMENT

I have received and understand the Welcome Packet information including the Patient's Rights and Responsibilities and DMEPOS Supplier Standards.

PATIENT EQUIPMENT ACKNOWLEDGEMENT (IF APPLICABLE PLEASE CHECK)

☐ I acknowledge that I have received the manufacturing instructions for the patient equipment provided by the Memorial Specialty Pharmacy Services.

MHS PRIVACY NOTICE ACKNOWLEDGEMENT

I hereby acknowledge receipt of the MHS Privacy Notice, which provides information about how Memorial Healthcare System, its employees, agents and your personal doctors and other health care professionals caring for you in MHS facilities, may use and disclose protected heath information about you.

Name: _____ Date: _____

Signature: _____

Or

Signature of Patient's Legal Personal Representative: _____

Relationship: _____ Date: _____