Mid-Shore Mental Health Systems, Inc.
MAI (GZ) Medical Assistance Ineligible
Pharmacy Assistance Request Form

Date: _____

Consumer: _____ SS# : _____ DOB: _____

Address: _____ County: _____

Consumer or Contact Person Telephone #: _____

Please **print** the prescribed Medication(s) & Cost per Prescription **(attach copy of current prescription)**:

_____$_____ _____$_____
_____$_____ _____$_____
_____$_____ _____$_____

Total Cost of Prescriptions: $_____

Participating Pharmacies (please circle): Cantner's Craig's Craig's Institutional
Denton Pharmacy Edward's Hill's Stam's

Does the client have private insurance? Yes No Have they applied for Med Bank? Yes No
Have available samples of medication been accessed? Yes No
Is client a consumer of Public Mental Health System? Yes No
Provide a statement indicating all other resources, including PAC (**include a copy of the PAC application with this initial request**) and the Indigent Drug program, which have been explored or accessed: How will payment occur when assistance ends?

_____
_____

Requestor: _____ Agency:_____ Phone:_____

IF this is a subsequent application, the consumer must call PAC (800-226-2142) to determine the status of their application and you must provide the tracking #. Once approved the medication must be obtained from the pharmacy within 48 hours.

CSA USE ONLY

Consumer Co-pay: $_____
Amount of MSMHS Approval: $_____
Total Amount of Prescriptions: $_____

Authorized Signature: _____ Date: _____

Executive or Clinical Director's Signature: _____ Date:_____

Posted _____ Consumer File _____ Paid Pharmacy_____ Reimbursed _____
Date Date Date Date