**Mid Shore Behavioral Health, Inc.**
**Consumer Support Services**
**Pharmacy Assistance Request Form**

Date: _______________

Consumer:______________________________ SS#:_______________ DOB:________ County:___________________
Address:_______________________________________ Consumer/Contact Person Telephone #:________________
Veteran: Yes No Gender: ___________ Primary Language:_____________________________
Ethnicity: African American Caucasian Hispanic Asian Native American Other Unknown

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

__________________________________$__________ _______________________________________$______
__________________________________$__________ _______________________________________$______
__________________________________$__________ _______________________________________$______
__________________________________**$**__________ _______________________________________$______

**Total Cost of Prescriptions**: $______________

**Participating Pharmacies (please circle)** Cantner's Craig's Craig's Institutional

Ridgely Edward's Hill's Stam's Chestertown Pharmacy

| | | |
|---|---|---|
| Is client a consumer of Public Behavioral Health System? | Yes | No |
| Check all that apply: ___Mental Health ___Substance Use/Addictions | | |
| Does the client have private insurance? | Yes | No |
| Have available samples been accessed? | Yes | No |
| Have they applied for Med Bank? | Yes | No |
| Have they applied for Medical Assistance? | Yes | No |

Provide a statement indicating all other resources, including Medicaid (**include a copy of the Medicaid application with this initial request**) and the Indigent Drug program, which have been explored or accessed: How will payment occur when assistance ends?
______________________________________________________________________________________________

**IF this is a subsequent application, the consumer must call Medicaid (855-642-8572) to determine the status of their application and must provide the tracking #: _______________________**
**Once approved the medication must be obtained from the pharmacy within 48 hours.**
**There is a $2.00 co-pay per medication.**

Requestor: _____________________________ Agency: _______________________ Phone: ________________
______________________________________________________________________________________________

**<u>CSA USE ONLY</u>**
**<u>Medicaid ID Number:</u>** _________________________

Consumer Co-pay: $__________________
Amount of MSBH Approval: $__________________
Total Amount of Prescriptions: $__________________

Authorized Signature: ______________________________________ Date: _________________

Executive Director, Deputy Director, or Board President Signature: __________________________________
Date: _________________

**Posted** _________ **Consumer File** _________ **Paid Pharmacy**_________
Date Date Date