Financial Responsibility Form

4700 WISSAHICKON AVE • 215-438-3308

Unit Name: ____ Date: _____________

Consumer Name: ____

Prescribed Medication: ____

Number of Pills Authorized: ____

Reason Drug Not Covered: ____

Cost of Medication: $_______________

Clinical Staff Authorization:

**** This form intends to recognize that the above-mentioned unit is assuming the financial coverage of the above listed amount should the consumer's insurance not cover this medication.**

This form must be filled out entirely before SQA Pharmacy will deliver the medication to the unit.

Please complete and fax back to SQA Pharmacy at (215) 951-6285

***Service, Quality, and Accuracy…* Not Just Our Name- Our Business!**

Revised 8/01/08