Pharmacy Billing Information

Hogan Pharmacy Partners Ltd. ("Hogan Pharmacy"), the contracted pharmacy for this Residence, will bill the Ontario Drug Benefit Program ("ODB" Government Drug Plan) directly for all medications covered by the plan. For more information on the ODB Program please visit http://www.health.gov.on.ca/en/public/programs/drugs/

For any copay amounts and for medications NOT covered by the ODB program, Hogan Pharmacy will bill your PRIVATE DRUG PLAN if you have one, or otherwise bill you directly on a monthly basis. Examples of medications not covered by the ODB program include most vitamins and supplements, some "over the counter" medications such as low dose aspirin, and some prescription medications.

In order to assist us in the billing process, please complete the following information:

1. Resident's NAME:_____Home/Suite_____
   Room Number:_____ Health Card Number: _____

2. Do you have a private drug insurance plan, such as Veterans Affairs, Blue Cross, Green Shield, Assure, etc.? If so, please provide the information below:

   Name of Drug Plan Provider_____

   Group Number_____Plan ID Number_____Carrier ID_____

3. How would you like to pay Hogan Pharmacy for any prescription costs?
   ☐ By Credit Card…***Please complete the attached Pre-Authorized Payment Plan Form.***
   ☐ By Pre-Authorized Bank Withdrawal…***Please complete the attached Pre-Authorized Payment Plan Form.***

4. Your billing statements will be sent by email to:

*(email address)*_____

Please return this form to pharmacy in the Hogan Mailbox in the Home Lobby,
OR mail to Hogan Pharmacy 704-B Eagle St. N Cambridge ON N3H 1C3 OR fax to 226-894-3772

Pre-Authorized Payment Form

Resident Name:_____

Resident Health Card Number:_____

Residence: _____

Responsible Party Name:_____

Phone Number:_____

Credit Card

I authorize Hogan Pharmacy Partners Ltd. to debit my credit card with the amount due shown on my monthly pharmacy billing statement:

□ VISA □ Mastercard □ AMEX

Card Holder's Name:_____

Credit Card Number:_____Expiry Date:_____

Security Code (CVV) :_____

Card Holder's Signature:_____ Date:_____

Pre-authorized Debit (PAD) Agreement

These services are for: □ Personal □ Business

I authorize Hogan Pharmacy Partners Ltd. to debit my bank account **(attach void cheque)** for the amount due shown on my monthly pharmacy billing statement, on the 15th of the month following the billing month.:

Financial Institution Number (3 digit):_____ Branch Transit Number (5 digit):_____

Bank Account Number: _____

Bank Account Holder's Name: _____

Bank Account Holder's Signature: _____ Date _____

I may revoke my authorization at any time by email or by phone, subject to providing notice of at least ten (10) business days. Please call 1-888-223-1011 extension 102 or email HPPAccounts@hoganrxgroup.com . For more information on your right to cancel a PAD agreement I may contact my financial institution or visit www.cdnpay.ca

I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with the PAD agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca

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