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,
<u>OR</u> mail to Hogan Pharmacy 704-B Eagle St. N Cambridge ON N3H 1C3 <u>OR</u> fax to 226-894-3772

Payment Option Form

Resident Last Name: ___________________________________

Resident First Name: ___________________________________

Home: ____

Responsible Party Name: ________________________________

Contact Phone Number: _________________________________

Instructions - Please select one (1) payment option from the 4 listed below:

Option 1 - Pre-Authorized Credit Card

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

☐ VISA ☐ Mastercard

Card Holder's Name: ____

Credit Card Number: ____

Expiry Date: _____________ Security Code (CVV) :_______

Card Holder's Signature: ____

Date Signed: ______________________________

Option 2 - Pre-authorized Debit (PAD) Agreement

These services are for: ☒ Personal

I authorize Hogan Pharmacy Partners Ltd. to debit my bank account **(attach void cheque or pre-authorized form from institution)** for the amount due shown on my monthly pharmacy billing statement, on the 15th of the month (or closest business day to) following the billing month.:

Account Holder's Name: ____

Account Holder's Signature: ____

Date Signed: _____________________________

HOGAN
PHARMACY PARTNERS LTD.

Payment Option Form

Option 3 - On-Line Banking

1. Under "Payee" type **Hogan**

2. Select **Hogan Pharmacy Partners**

3. Your Account Number is the number on the Statement, example: 1234ABCD

Bill To: Patient Omni Test
Account# 1234ABCD
123 Anywhere
City ON A1B 2C3

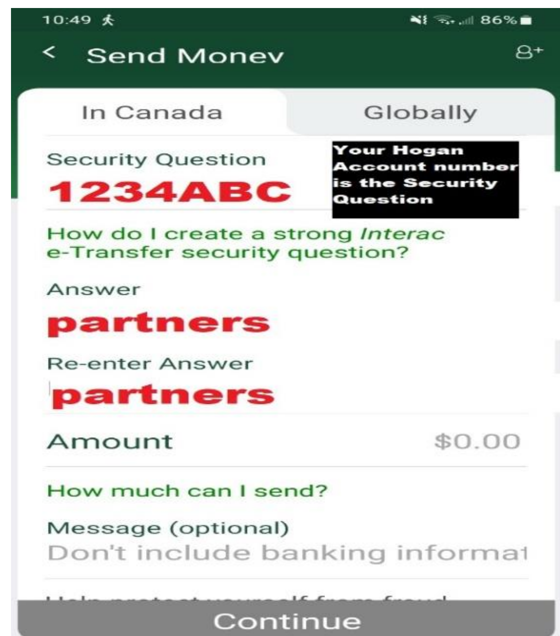
Option 4 – Interact e-Transfer

Send to: **hpp_accounts@hoganrxgroup.com**

Security Question: Your Account Number is the number on the Statement, example: 1234ABC

Bill To: Patient Omni Test
Account# 1234ABCD
123 Anywhere
City ON A1B 2C3

Password: **partners**



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 hpp_accounts@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

Please return this form to reception OR fax to 226-894-3772