WELCOME!

We would like to welcome you to East Tennessee Pharmacy Services, A Guardian Pharmacy. We are your community's provider of choice. Through our partnership, we can deliver the best possible service and ensure you get the medications you need, when you need them, safely – and at the right price.

WHY USE GUARDIAN?

- **Cost Management** – Guardian coordinates directly with your physicians and third-party insurance providers to ensure minimal out-of-pocket medication costs
- **Billing Support** – Unlike a retail pharmacy, Guardian bills medications monthly, and their local billing staff is always ready to answer billing-related questions
- **Medicare Guidance** – The pharmacy helps you understand your Medicare Part D coverage and can offer one-on-one consultations during open enrollment
- **Clinical Support** – Guardian conducts ongoing medication reviews to ensure you're on the appropriate drug regimen
- **Compliance Packaging** – Easy-to-use packaging options, required by our community, organize your medications and minimize the risk of error
- **Timely Delivery** – Scheduled and emergency deliveries are available 24/7, eliminating trips to a local retail pharmacy
- **Integrated Technology –** Guardian's seamless integration of our community's electronic medication administration record (eMAR) system eliminates transcription errors and improves medication management

Guardian designs services to make sure you never have to worry about your medication needs. Our team of pharmacists, pharmacy technicians, billing specialists, nursing team and delivery drivers work diligently to provide excellent customer services to every community and resident we are privileged to service. We appreciate the trust you have placed in us and are committed to earning your continued patronage. If you have any questions or concerns, please phone a pharmacy representative at (855) 544-4449.

PHARMACY SERVICES AGREEMENT

East Tennessee Pharmacy Services
431 Park Village Drive Suite 105
Phone: (865) 730.4200 Fax: (866) 944.4448

This is an agreement for pharmacy services with East Tennessee Pharmacy Services and _____ and
_____.
[RESPONSIBLE PARTY]

[RESIDENT]

In exchange for East Tennessee Pharmacy Services agreement to provide me with medications, I agree to the following terms and conditions:

1. **AUTHORIZATION FOR MEDICAL TREATMENT**. I authorize East Tennessee Pharmacy Services, at the direction of my physician, to provide medications to me. I certify that no guarantee or promise, express or implied, has been made to me in conjunction with the medications that have been prescribed for me.
2. **MEDICAL RESPONSIBILITY**. I understand that I am under the supervision and control of my attending physician and that my physician has prescribed the medication therapy that is being supplied by East Tennessee Pharmacy Services. East Tennessee Pharmacy Services does not provide diagnostics, prescriptions, products, or other functions unless otherwise authorized in writing by a physician. Accordingly, I understand that it is solely the responsibility of my physician to advise me on prescription medications and therapies, including why they are part of my treatment and how they may impact my condition.
3. **FACILITY INVOLVEMENT**. I understand and agree that in order to provide me with the best treatment possible, East Tennessee Pharmacy Services may share health information related to my medical condition, treatment, medication regimen, etc. with my long-term care facility or any of my treating physician. In recognition of this need, I authorize East Tennessee Pharmacy Services to share any necessary patient health information related to me with my facility or physician. I also authorize facility personnel to purchase medications, or other health care products that I may need, on my behalf.
4. **FINANCIAL RESPONSIBILITY**. In consideration of East Tennessee Pharmacy Services supplying me with physician-requested products or services, I agree and accept responsibility for the payment of all sums that may become due for medications provided to me by East Tennessee Pharmacy Services. If, for any reason, East Tennessee Pharmacy Services does not receive payment from my insurer or a third-party payor that is obligated to pay for my medications, I do hereby agree to pay East Tennessee Pharmacy Services directly for the unpaid balance within thirty (30) days of each monthly statement date. A credit card may be required to secure your account. Some commercial insurance plans do not cover Long Term Care (LTC) Services. If your plan does not cover these services, a fee for LTC services received may be reflected on your statement.
5. **PAYMENT OF BENEFITS.** I authorize East Tennessee Pharmacy Services to submit a claim(s) to my insurance carrier or a third-party payor that is obligated to pay for all covered prescriptions or durable medical equipment. I further direct my insurance carrier or third-party payor to issue any payments directly to East Tennessee Pharmacy Services.
6. **ASSIGNMENT OF BENEFITS.** I authorize East Tennessee Pharmacy Services to request and collect on my behalf all public and private benefits due for the products and services supplied by East Tennessee Pharmacy Services. In the event any payments are made directly to me, I agree to promptly endorse and forward such payment to East Tennessee Pharmacy Services.
7. **UNPAID INVOICES.** East Tennessee Pharmacy Services encourages residents to keep their accounts in good standing. However, if my account becomes past due, I agree that any amounts outstanding for more than thirty (30) calendar days shall bear interest from the due date of such invoice, at the lesser of one and a half percent (1.5%) per month or the maximum rate permitted by applicable law. I further agree to pay all costs or expenses incurred by East Tennessee Pharmacy Services related to collection efforts, including reasonable attorneys' fees and court costs.
8. **WITHHOLD SERVICES.** East Tennessee Pharmacy Services reserves the right to discontinue services to my account if I have not paid the account in full within 60 days. Payments that remain delinquent may be turned over to collections.
9. **RELEASE OF INFORMATION.** I authorize any insurer or third-party payor who provides me with coverage to disclose to East Tennessee Pharmacy Services any information regarding such coverage, including but not limited to the scope and extent of coverage available, as well as information related to any payments made on my behalf for services rendered by East Tennessee Pharmacy Services. I also authorize all medical personnel to disclose information to East Tennessee Pharmacy Services relating to my medical history as it related to pharmacy services or therapy.
10. **HIPAA AUTHORIZATION.** I give permission to East Tennessee Pharmacy Services to use or disclose certain aspects of my health information to the individual listed as my personal representative, my long-term care facility, federal and state health agencies, insurance companies, third-party data aggregators, pharmacy benefit managers, and other health-related agencies.

NOTICE OF PRIVACY PRACTICES [http://guardianpharmacy.net/hipaa-privacy-policy/]

I certify that I have received a copy of East Tennessee Pharmacy Services privacy practices and have been given an opportunity to review the document and ask questions to assist my understanding of resident's rights relative to the protection of resident's health information. I know that I can access the Notice of Privacy Practices on the Guardian Pharmacy website at [http://guardianpharmacy.net/hipaa-privacy-policy/]. I further acknowledge that I am satisfied with the explanations provided to me and am confident that East Tennessee Pharmacy Services is committed to protecting my health information. I certify that I have read and understand this agreement:

NOTICE OF NON-DISCRIMINATION AND COMPLAINT PROCEDURES

I certify that I have received a copy of East Tennessee Pharmacy Services Notice of Non-Discrimination and Complaint Procedures and have been given an opportunity to and did review the document including the free disabilities aids and language services available and was given an opportunity to ask questions to assist my understanding of it. I am confident I understand my rights and my options if I believe I have been discriminated against or guardian has failed to provide certain services.

MEDICARE CAPPED RENTAL & INEXPENSIVE OR ROUTINELY PURCHASED ITEMS

I received instructions and understand that Medicare defines the _____ that I received as being either a capped rental or an inexpensive or routinely purchased item. I have been given the opportunity to and did examine the Medicare Capped rental and inexpensive or routinely purchased items notification and was given an opportunity to ask questions to assist my understanding of it.

INJURY, INFECTION AND EMERGENCY PREPAREDNESS

I certify that I have received a copy of East Tennessee Pharmacy Services Injury, infection, and emergency preparedness protocol and have been given an opportunity to and did review the document and was given an opportunity to ask questions to assist my understanding of it.

PAYMENT INFORMATION

I certify that I have received a copy of East Tennessee Pharmacy Services payment information and understand the available ways to pay my bills and have been given an opportunity to and did review the document and was given an opportunity to ask questions to assist my understanding of it.

I UNDERSTAND AND HAVE REVIEWED THE NOTICE OF PRIVACY PRACTICES, THE NOTICE OF NON-DISCRIMINATION AND COMPLAINT PROCEDURES, THE MEDICARE CAPPED RENTAL & INEXPENSIVE OR ROUTINELY PURCHASED ITEMS, INJURY, INFECTION AND EMERGENCY PREPAREDNESS, AND THE PAYMENT INFORMATION DOCUMENTS AND AGREE TO BE BOUND BY THEM.

Signature [Resident or Responsible Party]**:** _____ **Date:** _____

431 Park Village Road, Suite 105, Knoxville, TN 37923
Phone: 865.730.4200 Fax: 866.944.4448

MEDICAL INFORMATION (HIPAA) RELEASE FORM

Resident Name: _____

Date of Birth: _____

Release of Information

I AUTHORIZE THE RELEASE OF INFORMATION INCLUDING PRESCRIPTION RECORDS RENDERED TO ME AND CLAIMS INFORMATION. THIS INFORMATION MAY BE RELEASED TO:

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

The release of information will remain in effect until terminated by client in writing.

Messages

Is it okay to leave messages if unable to reach you? Yes _____ No _____

If unable to reach me:

☐ Leave a detailed message

☐ Leave a message requesting a return phone call

Resident Signature: _____ Date: _____

OR

I _____ am a power of attorney for resident

A COPY OF THE POA PAPERWORK MUST BE ATTACHED TO VALIDATE

POA Signature: _____ Date: _____

RESIDENT ENROLLMENT FORM

RESIDENT INFORMATION

RESIDENT NAME _____

_____

[FIRST] [MIDDLE INITIAL] [LAST]

SSN# __-_____-_____ DOB _____/_____/_____ MEDICARE ID# _____ □ MALE □ FEMALE

COMMUNITY NAME _____ APT# _____

PRIMARY CARE PHYSICIAN _____ PHYSICIAN PHONE _____

MEDICAL DIAGNOSIS _____ ALLERGIES _____

PRESCRIPTION DRUG INSURANCE

PRESCRIPTION INSURANCE PLAN _____ CARDHOLDER ID# _____

RX GROUP# _____ RX BIN# _____ PCN# _____

RELATIONSHIP TO CARDHOLDER: □ SELF □ SPOUSE □ OTHER _____

**A PHOTOCOPY OF THE INSURANCE CARD [FRONT AND BACK] MUST BE INCLUDED FOR THE PHARMACY TO PROCESS INSURANCE TO GAIN THE MOST BENEFITS FOR THE PATIENT.*

RESPONSIBLE FINANCIAL PARTY INFORMATION

PRIMARY _____ RELATIONSHIP TO RESIDENT _____

[FIRST] [LAST]

PHONE (____) _____ □ HOME □ CELL EMAIL _____

ADDRESS* _____

[STREET] [CITY] [STATE] [ZIP CODE]

*****MONTHLY STATEMENTS WILL BE MAILED TO THE PRIMARY ADDRESS LISTED ABOVE UNLESS OTHERWISE REQUESTED***

SECONDARY _____ RELATIONSHIP TO RESIDENT _____

[FIRST] [LAST]

PHONE (____) _____ □ HOME □ CELL EMAIL _____

ADDRESS* _____

[STREET] [CITY] [STATE] [ZIP CODE]

****SECONDARY MUST BE COMPLETED IF RESIDENT IS LISTED AS THE PRIMARY CONTACT***

ETPS RESIDENT ENROLLMENT FORM

PAYMENT INFORMATION

A valid credit card or ACH payment method is required to be kept on file to secure this account. Please fill out one of the boxes below based on your preferred payment method.

ACH / Checking Account

NAME OF BANK _____ NAME ON ACCOUNT_____

ROUTING NUMBER_____ ACCOUNT NUMBER _____

Credit Card

TYPE OF CARD (circle): VISA MASTERCARD AMERICAN EXPRESS DISCOVER

NAME ON CARD _____ CARD NUMBER _____

BILLING ADDRESS _____ EXPIRATION (MMYY) _____/_____

_____ SECURITY CODE _____

*VISA/MC/DISCOVER: 3 digits on back of card
*AMEX: 4 digits on front of card

Please select an option below and sign.

☐ *I wish to pay automatically by credit card each month – please enroll me in autopay.*

☐ *I wish to pay automatically by electronic check each month – please enroll me in autopay.*

☐ *I will mail in payment by check each month, pay monthly via online credit card portal, or call to pay by phone each month, promptly after receipt of Guardian's statement. **

*If payment is not received from resident within 60 days, Guardian will attempt to contact the responsible party. After which, if payment still has not been received, payment will be drafted from card on file. Credit card will only be used after Guardian notifies responsible party of non-payment of an outstanding balance. Guardian reserves the right to withhold services if payment is 90 days or more past due and no good faith effort has been made to bring the balance current. Payments that remain delinquent may be turned over to collections and reported to credit reporting agencies.

RESIDENT OR RESPONSIBLE PARTY SIGNATURE _____

ETPS PAYMENT INFORMATION

East Tennessee Pharmacy Services understands life is busy and we want to make it as convenient as possible to take care of your payment obligation and offers three easy and convenient ways to pay your pharmacy bills. In addition, our team is always a phone call away to assist in helping you understand your bill.

ONLINE BILL PAY 💻

The online portal is flexible, easy to use, and available 24/7. Manage multiple users and accounts, monitor payment activity, view your statements and enroll in electronic statement delivery.

Create an account in our online payment portal to make a one-time payment or set up automatic recurring payments. Recurring payments take the hassle out of remembering to pay your bill by allowing you to choose the date that your monthly payment is processed. Payments can be made via your checking account or credit card (VISA, Mastercard, American Express).

The website link to the online portal is **payetps.easttennpharm.com** This link can also be found on your monthly statements.

PAY BY PHONE ☎

Use our automated payment system to make a payment by phone using the access code and zip code listed on your statement. Payments can be made via your checking account or credit card (VISA, Mastercard, American Express) by calling **855.474.3850**. This number can also be found on each monthly statement.

PAY BY MAIL ✉

Mail in a check or money order payment directly to the address listed on your statement to make a payment. If paying by check or money order, please include your name or account number. If we receive any non-sufficient funds check, please understand and agree that ETPS may charge a forty ($40) dollar service charge and give you an opportunity to rectify the payment by sending another check without a break in service if contacted within 72 hours of receipt of insufficient funds.

Pharmacy billing address:

ETPS
P.O. Box 415000, MSC 7518
Nashville, TN 37241-7518

If you have any questions regarding your bill or how to use one of these payment methods, please feel free to reach out to the ETPS billing team for assistance @ 833.442.9717.

Dear Valued Customer:

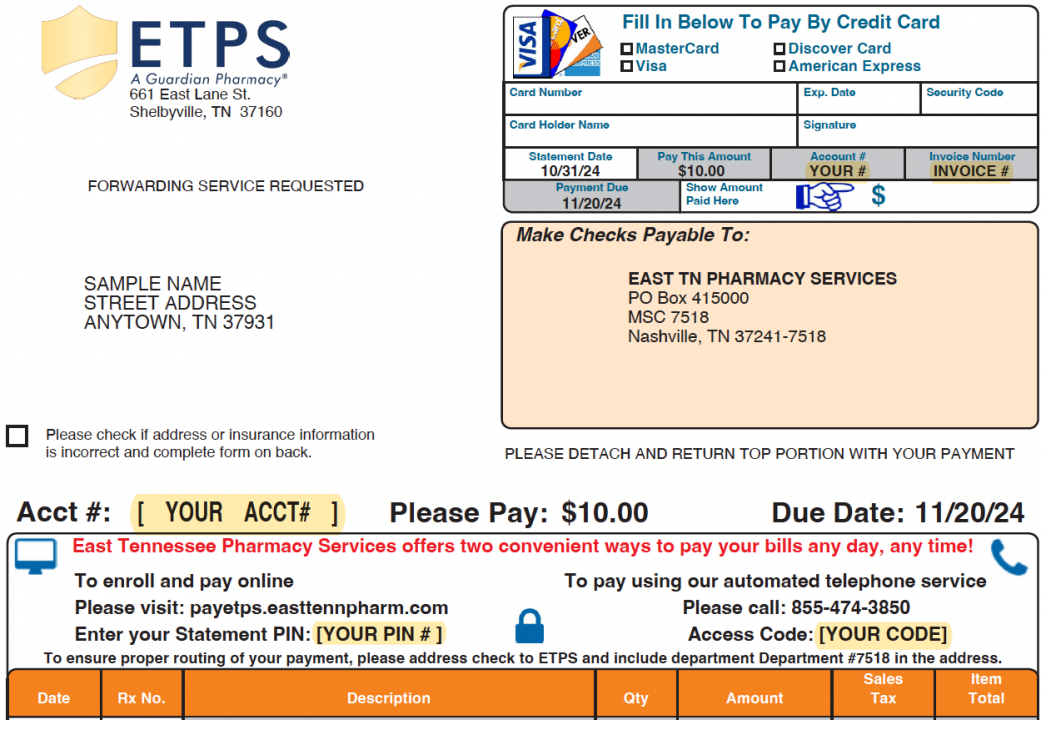
We would like to thank you for being an East Tennessee Pharmacy Services Customer. We pride ourselves in excellent customer service and strive to handle all of your pharmaceutical and billing needs with the utmost care.

Our Billing Team here at ETPS would like to share with you some of the different payment options we offer. In an attempt to make things more convenient for our customers, we have provided you with 3 different payment options: 1.) payment by an automated phone system, 2.) payment via postal mail and 3.) payment via online payment website. Also, assuring we have all your contact information on the enclosed Pharmaceutical Purchase Agreement will help us help you in filing your insurance and getting the most out of your benefits for you!

Below you will find an example of what our statements look like that you will receive. We have indicated where you can find the information specific to your account. We have also provided you with a list of answers to some of our most frequently asked questions in this packet. If you have any further questions or need assistance with any payment options, please don't hesitate to reach out to our customer service department who will be glad to assist.

Sincerely,

Your Customer Service Team @ East Tennessee Pharmacy Services
833.442.9717



ETPS
A Guardian Pharmacy®
661 East Lane St.
Shelbyville, TN 37160

FORWARDING SERVICE REQUESTED

SAMPLE NAME
STREET ADDRESS
ANYTOWN, TN 37931

Please check if address or insurance information is incorrect and complete form on back.

Fill In Below To Pay By Credit Card

MasterCard Discover Card
Visa American Express

Card Number	Exp. Date	Security Code
Card Holder Name	Signature	

Statement Date	Pay This Amount	Account #	Invoice Number
10/31/24	$10.00	YOUR #	INVOICE #
Payment Due 11/20/24	Show Amount Paid Here	$	

Make Checks Payable To:

EAST TN PHARMACY SERVICES
PO Box 415000
MSC 7518
Nashville, TN 37241-7518

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

Acct #: [YOUR ACCT#] Please Pay: $10.00 Due Date: 11/20/24

East Tennessee Pharmacy Services offers two convenient ways to pay your bills any day, any time!

To enroll and pay online
Please visit: payetps.easttennpharm.com
Enter your Statement PIN: [YOUR PIN #]

To pay using our automated telephone service
Please call: 855-474-3850
Access Code: [YOUR CODE]

To ensure proper routing of your payment, please address check to ETPS and include department Department #7518 in the address.

Date	Rx No.	Description	Qty	Amount	Sales Tax	Item Total

If you have any questions regarding your bill or how to use one of these payment methods, please feel free to reach out to the ETPS billing team for assistance @ 833.442.9717.

THE RIGHT TO CHOOSE YOUR PHARMACY PROVIDER

PHARMACY OPT-OUT

Your community has chosen ETPS as its preferred pharmacy because of the outstanding service we provide to our residents. However, the Centers for Medicare and Medicaid Services (CMS) guarantees a beneficiary his or her right to a choice of pharmacy providers. We sincerely hope you choose ETPS as your provider, but we will honor your choice if you prefer another provider.

This form is only for those who do NOT wish to receive their medications from ETPS and would like to "opt-out" or decline the services provided by ETPS.

By signing this form, you are acknowledging the following:

- You are choosing to use a pharmacy provider that is not ETPS.
- You agree to assume the responsibility of tracking, ordering, and having prescription medications delivered to your community.
- You agree to incur the fee charged by your community each month for utilizing a non-preferred pharmacy.
- If a prescribed medication is not available for administration, I consent my community to order a 7-day supply from ETPS at my cost while I arrange to have another provider deliver a full supply of the medication. My community is obligated by the State of TN to administer medications as they are ordered and an excuse of "not available" is not permissible.

If you would like to use your community's preferred provider, ETPS, please disregard the signature block below. Sign below ONLY if you wish to use a pharmacy other than ETPS.

_____ _____

Resident/Responsible Party Date

_____ _____

Community Representative Date

East Tennessee Pharmacy Services, LLC

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

I. Our duty to safeguard your protected health information

We are committed to preserving the privacy and confidentiality of your health information. We are required by certain state and federal regulations to implement policies and procedures to safeguard your health information. Copies of our privacy policies and procedures are maintained in our business office. We are required by state and federal regulations to abide by the privacy practices described in this notice, including any future revisions that we may make to the notice as may become necessary or as authorized by law.

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care treatment or services you receive is considered *protected health information* (PHI). Accordingly, we are required to provide you with this Privacy Notice that contains information regarding our privacy practices to explain how, when and why we may use or disclose your PHI and your rights and our obligations regarding any such uses or disclosures. Except in specified circumstances, we must use or disclose only the minimum amount of PHI necessary to accomplish the intended purpose of the use or disclosure of such information.

We reserve the right to change this notice at any time and make the revised or changed notice effective for PHI that we already have about you as well as any information we receive in the future about you. Should we revise/change this Privacy Notice, we will promptly notify you of the revision/change. You also may request and obtain a copy of any new/revised Privacy Notice from the contact person identified on the last page of this notice.

Should you have questions concerning our Privacy Notice, our contact information is listed on the last page of this document.

II. How we may use and disclose your protected health information

We use and disclose protected health information for a variety of reasons. We have a limited right to use and/or disclose your protected health information for purposes of treatment, payment, or for health care operations. For other uses and disclosures, you must give us your written authorization to release your protected health information unless the law permits or requires us to make the use or disclosure without your authorization.

Should it become necessary to release or give access to your protected health information to an outside party performing services on our behalf (e.g., maintaining our computers), we will require the party to have a signed agreement with us that the party will extend the same degree of privacy protection to your information as we do.

The privacy law permits us to make some uses or disclosures of your protected health information without your consent or authorization. The following describes each of the different ways that we may use or disclose your protected health information. Where appropriate, we have included examples of the different types of uses or disclosures. These include:

1. Use and Disclosures Related to Treatment

We may disclose your protected health information to those who are involved in providing medical and nursing care services and treatments to you. For example we may release protected health information about you to nurses, nursing assistants, medication aides/technicians, medical and nursing students, therapist, other pharmacist, medical records personnel, other

consultants, physicians, etc. We may also disclose your protected health information to outside entities performing other services relating to your treatment; such as assisted living facilities, long term care facilities, hospitals, diagnostic laboratories, home health/hospice agencies, family members, etc.

2. Use and Disclosures Related to Payment

We may use or disclose your protected health information to bill and collect payment for items or services w provided to you. For example, we may contact your insurance company, health plan, or another third party to obtain payment for services we provided to you.

3. Use and Disclosures Related to Health Care Operations

We may use or disclose your protected health information for the performance of certain functions in monitoring and improving the quality of care and services that you and others receive. For example, we may use your protected health information to evaluate the effectiveness of the care and services you are receiving. We may also disclose your protected health information for auditing, care planning, quality improvement, and learning purposes.

4. Use and Disclosures Related to Treatment Alternatives, Health-Related Benefits and Services

We may use or disclose your protected health information for purposes of contacting you to inform you of treatment alternatives or health-related benefits and services that may be of interest to you, such as a newly released medication to treatment that has a direct relationship to a treatment that has a direct relationship to a treatment or medical condition.

III. Uses and Disclosures Requiring Your Written Authorization

For uses and disclosures of your protected health information beyond the above excepted purposes, we are required to have your written authorization, except as otherwise required or permitted by law. You have the right to revoke an authorization at any time to stop future uses or disclosures of your information except to the extent that we have already undertaken an action in an action in reliance upon your authorization. Your revocation request must be provided to us in writing. Our contact information for purposes of revoking your authorization is listed on the last page of this document. You may use our *Authorization for Use or Disclosure of Protected Health Information* form and/or our *Revocation of an Authorization* form to submit your request to us. Copies of these forms are available upon request.

Examples of uses or disclosures that would require your written authorization include, but are not limited to, the following:

1. A request to provide your protected health information to an attorney for use in a civil litigation claim.
2. A request to provide certain information to an insurance or pharmaceutical company for the purposes of providing you with information relative to insurance benefits or new medications that may be of interest to you.
3. A request to provide PHI to another individual or facility, where no exception from the written authorization requirement applies.

IV. Uses or Disclosures of Information Based Upon Your Verbal Agreement

In the following situations, we may disclose a limited amount of your protected health information if we provide you with an advance oral or written notice and you do not object to such release or such release is not otherwise prohibited by law. However, if there is an emergency situation and you are unable to object (e.g., because you were not present or you were incapacitated), disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interest. When a disclosure is made based on these or emergency situations, we will only disclose protected health information relevant to the person's involvement in your care. For example, if you are having an adverse reaction to a medication, and are not able to communicate with us effectively, we may inform a family member involved in your care of your drug regimen and possible side effects. You will be informed and given an opportunity to object to further disclosures of such information as soon as you are able to do so.

We may disclose your protected health information to your family members and friends who are involved in your care or who help pay for your care. We may also disclose your protected health information to a disaster relief organization for the purposes of notifying your family and/or friends about your general condition, location, and/or status (i.e., whether you are alive or dead). You may object to the release of this release of this information. You may use our *Request to Restrict the Use or Disclosure of Protected Health Information* form to notify us of your objection or your objection may be made orally. Our contact information is listed on the last page of this document. (See also Section VI, Paragraph 1.)

V. Uses and Disclosures of Information That Do Not Require Your Consent or Authorization

State and federal laws and regulations in some instances either require or permit us to use or disclose your protected health information without your consent or authorization. The uses or disclosures that we may make without your consent or authorization include the following:

1. **When Required by Law:**
   We may disclose your protected health information when required by federal, state, or local law.
2. **Abuse, Neglect, or Domestic Violence**:
   As required or permitted by law we may disclose protected health information about you to a state or federal agency to report suspected abuse, neglect, or domestic violence. If such a report is optional, we will use our professional judgment in deciding whether or not to make such a report. If feasible, we will inform you promptly that we have made such a disclosure.
3. **Communicable Diseases:**
   To the extent authorized by law, we may disclose information to a person who may have been exposed to a communicable disease or who is otherwise at risk of spreading a disease or condition.
4. **Disaster Relief:**
   We may disclose protected health information about you to government entities or private organizations (such as the Red Cross) to assist in disaster relief efforts.
5. **Food and Drug Administration (FDA):**
   We may disclose protected health information about you to the FDA, or to an entity regulated by the FDA, in order, for example, to report an adverse event r a defect related to a drug or medical device.
6. **For Public Health Activities:**
   As required or permitted by law, we may disclose protected information about you to a public health authority, for example, to report disease, injury, or vital events such as death.
7. **For Health Oversight Activities**:
   We may disclose your protected health information to a health oversight agency such as a protection and advocacy agency, or to other agencies responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents or to ensure that we are in compliance with applicable state and federal laws and regulations, including civil rights laws.
8. **To Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations or Tissue Banks**:
   We may disclose your protected health information to a coroner or medical examiner for the purpose of identifying a deceased individual or to determine the cause of death. We may also disclose your protected health information to a funeral director for the purpose of carrying out your wishes and/or for the funeral die\rector to perform his/her necessary duties.

   If you are an organ donor we may disclose your protected health information to the organization that will handle your organ, eye or tissue donation for the purposes of facilitating your organ or tissue donation or transplantation.
9. **For Research Purposes**:
   We may disclose your protected health information for research purposes without your authorization only when a privacy board has approved the research project. We may use or disclose your protected health information to individuals preparing to conduct an approved research project. We may use or disclose your protected health information to individuals preparing to conduct an approved research project in order to assist such individuals in identifying persons to be included in the research project. Researchers identifying persons to be included in the research project will not be permitted to remove protected health information from our control. If it becomes necessary to use or

disclose information about you that could be used to identify you by name, we will obtain your written authorization before permitting the researcher to use your information. Researchers will be required to sign *a Confidentiality and Non-Disclosure Agreement* form before being permitted access to protected health information for research purposes. A sample copy of this agreement may be obtained from our business office.

10. **To Avert a Serious Health Threat to Health or Safety:**
    We may disclose your protected health information to avoid a serious threat to your health or safety or to the health or safety of others. When such disclosure is necessary, information will only be released to those law enforcement agencies or individuals who have the ability or authority to prevent or lessen the threat of harm.
11. **For Judicial or Administrative Proceedings:**
    We may disclose protected health information about you in the course of a judicial or administrative proceeding, in accordance with our legal obligations.
12. **To Law Enforcement:**
    We may disclose protected health information about you to a law enforcement official for certain law enforcement purposes. For example, we may report certain types of injuries as required by law, assist law enforcement to locate someone such as fugitive or material witness, or make a report concerning a crime or suspected criminal conduct.
13. **Minors**:
    If you are an emancipated minor as defined under state law, there may be circumstances in which we disclose protected health information about you to a parent, guardian, or personating in *loco parentis*, in accordance with our legal and ethical responsibilities.
14. **Parents:**
    If you are a parent of an unemancipated minor, and are acting as the minor's personal representative, we may disclose protected health information about your child to you under certain circumstances. For example, if we are legally required to obtain your consent as your child's personal representative in order for your child to receive care or services from us, we may disclose protected health information about your child to you. For example, if your child is legally authorized to obtain services (without separate consent from you), and does not request that you be treated as his or her personal representative, we may not be required to disclose protected health information about your child to you without your child's written authorization.
15. **To Personal Representatives:**
    If you are an adult or emancipated minor, we may disclose protected health information about you to a personal representative authorized to act on your behalf in making decisions about your health care.
16. **For Specific Government Functions**:
    We may disclose protected health information about you for certain specialized government functions, as authorized by law. Among these functions are the following: military command; determination of veteran's benefits; national security and intelligence activities; protection of the President and other officials; and the health, safety, and security of correctional institutions.
17. **For Workers' Compensation:**
    We may disclose protected health information about you for purposes related to workers' compensation, as required and authorized by law.

VI. Your Rights Regarding Your Protected Health Information

You have the following rights concerning the use or disclosure of your protected health information that we create or that we may maintain about you:

1. **To Request Restrictions on Uses and Disclosures of Your Protected Health Information**:
   You have the right to request that we limit how we use or disclose your protected health information for treatment, payment or health care operations. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for your care or services. For example, you could request that we not disclose to family members or friends information about a medical treatment you received.

   Should you wish a restriction placed on the use and disclosure of your protected health information, you must submit such request in writing. Such *request* should be submitted using our *Request to Restrict the Use and Disclosure of*

Protected Health Information form. Our contact information for purposes of making such a request is listed on the last page of this document.

We are not required to agree to your restriction request. You will be informed if we decline your request. If we accept your request, we will comply with your request not to release such information unless the information is needed to provide emergency care or treatment to you.

2. The Right to Inspect and Copy Your Health and Billing Records:

You have the right to inspect and copy your protected health information, such as your prescription and billing records. In order to inspect and/or copy your protected health information, you must submit a written request to us. If you request a copy of your prescription or billing information or other records, we may charge you a reasonable fee for the paper, labor, mailing and/or retrieval costs involved in filing your request. We will provide you with information concerning the cost of copying your protected health information prior to performing such service. Such requests should be submitted on our *Request for Inspection/Copy of Protected Health Information* form. Our contact information for such requests is listed on the last page of this document.

We will respond within thirty (30) days of receipt of such request. Should we deny your request to inspect and/or copy your protected health information, we will provide you with written notice of our reasons of the denial and your rights for requesting a review of the denial, if any. In the event of a review, we will select a licensed health care professional not involved in the original denial process to review your request and our reasons for denial. We will abide by the reviewer's decision concerning your inspection/copy requests. Your denial review request should be submitted on our *Denial of Inspection/Copy of Protected Health Information form*. Copies of these forms are available from the contract person listed on the last page of this document.

3. The Right to Amend or Correct Your Protected Health Information:

You have the right to request that your protected health information be amended or corrected if you have reason to believe that certain information is incomplete or incorrect. You have the right to make such requests of us for as long as we maintain/retain your protected health information. Your requests must be submitted to us in writing. We will respond within sixty (60) days of receiving the written request, unless and extension is necessary, in which case you will be notified, and receive a response to your request within ninety (90) days. If we approve your request, we will make such amendments/corrections and notify those with a need to know of such amendments/corrections.

We will deny your request if:

a. Your request is not submitted in writing;
b. Your written request does not contain a reason to support your request;
c. The information was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
d. It is not a part of the protected health information kept by us;
e. It is not part of the information which you would be permitted to inspect and copy; and/or
f. The information is already accurate and complete.

If you request is denied, we will provide you with a written notification of the reason(s) of such denial and your rights to have the request, the denial, and any written response (of reasonable length) you may have relative to the information and denial process appended to your protected health information.

Your amendment/correction request should be submitted on your *Request for Amendment/Correction of Protected Health Information form*. Copies of these forms are available from our business office. Our contact information for the purpose of making such a request is listed on the last page of this document.

4. The Right to Request Confidential Communications:

You have the right to request that we communicate with you about your health matters in a certain way or at a certain location. For example, you may request that we not send any protected health information to you at a health care

facility, but instead send communication for you to a residential address or Post Office Box. We will agree to your as long as it is reasonable for us to do so.

You may submit your request on our *Request for Restriction of Confidential Communications form*. Copies of these forms are available from the contact person listed on the last page of this document. Our contact information is listed on the last page of this document.

5. **The Right to request an Accounting of Disclosures of Protected Health Information**:
   You have the right to request that we provide you with a listing of certain disclosures of your protected health information that we have made over a specified period of time. This accounting will not include any information we have made for the purposes of treatment, payment, or health care operations or information released to you, your family or friends for notification purposes. Disclosures made for national security purposes or to certain law enforcement officials, incidental disclosures, disclosures made as part of a limited data set (for use in research, public health, etc.), or any disclosures made pursuant to your authorization.

   Your request must be submitted to us in writing and must indicate the tine period for which you wish the information (e.g., May 1, 2003 through August 31, 2003). Your request may not include releases for more than six (6) years prior to the date of your request and may not include releases prior to April 14, 2003. Your request must indicate in what form (e.g., printed copy or email) you wish to receive this information. We will respond to your request with sixty (60) days of the receipt of your written request. Should additional time be needed to reply, you will be so notified. However, in no case will such extension exceed thirty (30) days. The first accounting you request during a twelve (12) month period will be free. There may be a reasonable fee for additional requests during the twelve (12) month period. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

   You may submit your request on our *Request for an Accounting of Disclosures of Protected Health Information form* available from our business office. Our contact information is listed on the last page of this document.

6. **The Right to Receive a Paper Copy of This Notice**:
   You have the right to receive a paper copy of this notice even though you may have agreed to receive an electronic copy of this notice. You may request a paper copy of this notice at any time or you may obtain a copy of this information from our website (as applicable). Our contact information is listed at the end of this page.

VII. How to File a Complaint About Our Privacy Practices

If you have reason to believe that we have violated your privacy rights or our privacy policies and procedures or if you disagree with a decision we made concerning access to your protected health information you have the right to file a complaint with us or the Secretary of the U.S. Department of Health and Human Services. You will not be retained against for filing a complaint.

You may submit your complaint on or privacy *Practices Complaint form* available from our business office. Our contact information is listed below:

Contact for Complaints: **Customer Service**, **East Tennessee Pharmacy Services**, **661 E. Lane St. Shelbyville, TN 37160, 833-442-9717**

Contact for HIPAA Compliance Officer: Robin Garner-Smith, East Tennessee Pharmacy Services, 431 Park Village Drive, Suite 105, Knoxville, TN 37923, 865-730-4200

Customer Procedure for Filing a Complaint

Our Pharmacy provides comprehensive care to the residents and staff of nursing facilities, assisted living facilities and retirement communities. Our pharmacy team prepares each patient's medication, and in consultation with healthcare professionals, patient files are reviewed by our pharmacist each time a prescription is filled.

We strive to provide every customer with superior service. If you believe that we may not have provided you with this level of service, we encourage you to let us know immediately by logging a complaint. By logging a complaint, you allow us to continue to improve our company by addressing and correcting any areas of concern.

We believe that every customer has the right to freely voice grievances and recommend changes in care or services without fear of reprisal or unreasonable interruption of services.

We take every complaint and concern seriously. All lodged complaints will be investigated, which includes a response within 5 days and a written notification within 14 days that provides resolution of the complaint. All complaints will be handled in a professional manner, and they will be promptly communicated to management and upper management as appropriate.

There are several ways that you can choose to log a complaint or concern.

1. **By Phone**: You can call us at (855) 544.4449 and speak to someone in person. Simply let them know you would like to file a complaint, and they can either mail you a complaint form for you to complete and submit or take your complaint over the phone.
2. **By Mail**: You can complete a complaint form (or write a letter) and mail it to our office:

   ETPS, Attn: Customer Service Department
   431 Park Village Road, Suite 105
   Knoxville, TN 37923

3. **By Email**: customerservice@mtpsltc.com

Please feel free to contact us anytime about any of your concerns.

Sincerely,
ETPS Customer Service

INJURY, INFECTION AND EMERGENCY PREPAREDNESS

INJURY PROTOCOL

In the event of an injury or death related to equipment failures provided by Guardian Pharmacy, LLC and its related entities would be reported to all authorities (state, local payer, accreditation provide as required). Guardian Pharmacy, LLC and its related entities reduces the risk through education and information provided to facilities, employees, and patients.

INFECTION CONTROL POLICY

Guardian Pharmacy, LLC and its related entities will maintain a plan of action regarding issues of infection and hazards by complying with CDC and OSHA standards, reviewing, updating, and reporting such concerns as they arise.

EMERGENCY PREPAREDNESS PLAN

Guardian Pharmacy, LLC and its related entities has a comprehensive emergency preparedness plan in case a disaster occurs. Disasters may include fire to our facility, chemical spills in the community, hurricanes, tornadoes and community evacuations. Our primary goal is to continue to service your health care needs. It is your responsibility to contact Guardian Pharmacy, LLC and its related entities regarding any medications or supplies you may require when there is a threat of disaster or inclement weather so that you have enough medication or supplies to sustain you.

If a disaster occurs, follow instructions from the civil authorities in your area. Guardian Pharmacy, LLC and its related entities will utilize every resource available to continue to service you. However, there may be circumstances where Guardian Pharmacy, LLC and its related entities cannot meet your needs due to the scope of the disaster. In that case, you must utilize the resources of your local rescue or medical facility. Guardian Pharmacy, LLC and its related entities will work closely with authorities to ensure your safety.

MEDICARE DMEPOS SUPPLIER STANDARDS

Note: This is an abbreviated version of the supplier standards every Medicare DMEPOS supplier must meet in order to obtain and retain their billing privileges. These standards, in their entirety, are listed in 42 C.F.R. 424.57(c).

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. A supplier must have an authorized individual (whose signature is binding) sign the enrollment application for billing privileges.
4. A supplier must fill orders from its own inventory, or contract with other companies for the purchase of items necessary to fill orders. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or any other Federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site and must maintain a visible sign with posted hours of operation. The location must be accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records.
8. A supplier must permit CMS or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll-free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.
11. A supplier is prohibited from direct solicitation to Medicare beneficiaries. For complete details on this prohibition see 42 CFR § 424.57 (c) (11).
12. A supplier is responsible for delivery of and must instruct beneficiaries on the use of Medicare covered items and maintain proof of delivery and beneficiary instruction.
13. A supplier must answer questions and respond to complaints of beneficiaries and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair cost either directly, or through a service contract with another company, any Medicare-covered items it has rented to beneficiaries.
15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these standards to each beneficiary it supplies a Medicare-covered item.
17. A supplier must disclose any person having ownership, financial, or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its Medicare billing number.
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and regulations.
22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is

accredited in order for the supplier to receive payment for those specific products and services (except for certain exempt pharmaceuticals).

23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
26. A supplier must meet the surety bond requirements specified in 42 CFR § 424.57 (d).
27. A supplier must obtain oxygen from a state-licensed oxygen supplier.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 CFR § 424.516(f).
29. A supplier is prohibited from sharing a practice location with other Medicare providers and suppliers.
30. A supplier must remain open to the public for a minimum of 30 hours per week except physicians (as defined in section 1848(j) (3) of the Act) or physical and occupational therapists or a DMEPOS supplier working with custom made orthotics and prosthetics.

NOTICE OF NON-DISCRIMINATION

Guardian Pharmacy, LLC and its related entities comply with applicable federal, state and civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex or any other protected status. In addition, Guardian:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Auxiliary aids and services
- Written information in other formats

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Guardian at (865) 730.4200.

If you believe that Guardian has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, or any other protected status, you can file a grievance with *Guardian's Compliance Department* by calling 1-866-827-5477.

If you feel your concern is not addressed you can file a grievance with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

COMPLAINT PROCEDURES

You have the right and responsibility to express concerns, dissatisfaction or make complaints about services you do or do not receive without fear of reprisal, discrimination or unreasonable interruption of services.
The telephone number is 1-866-827-5477; when you call you will be directed to a compliance specialist.

If you follow this process, we will ensure your concerns will be reviewed, investigated and responded to in accordance with state and federal regulations.

MEDICARE PATIENTS

If your concern is not addressed, you can file a complaint/or speak to a customer service representative at Medicare by calling 1-800-MEDICARE or 1-800-633-4227

BILL OF PATIENT RIGHTS AND RESPONSIBILITIES

As our customer, you are hereby provided this Bill of Rights. You have the right to be notified in writing of your rights and obligations before treatment has begun. The patient's family or guardian may exercise the patient's rights when the patient has been judged incompetent. We fulfill our obligation to protect and promote the rights of our patients, including the following:

RIGHTS: As the patient/caregiver, you have the right to:

- Be treated with dignity and respect
- Confidentiality of patient records and information pertaining to a patient's care
- Be presented with information at admission in order to participate in and make decisions concerning your plan of care and treatment
- Be notified in advance of the types of care, frequency of care, and the clinical specialty providing care
- Be notified in advance of any change in your plan of care and treatment
- Be provided equipment and service in a timely manner
- Receive an itemized explanation of charges
- Be informed of company ownership
- Express grievance without fear of reprisal or discrimination.
- Receive respect for the treatment of one's property
- Be informed of potential reimbursement for services under Medicare, Medicaid or other 3rd party insurers based on the patient's condition and insurance eligibility
- Be notified of potential financial responsibility for products or services not fully reimbursed by Medicare, Medicaid or other third-party insurers. (to the best of our knowledge)
- Be notified within 30 working days of any changes in charges for which you may be liable
- Be admitted for service only if the company can provide safe, professional care at the scope and level of intensity needed, if ETPS is unable to provide services then we will provide alternative resources
- Purchase inexpensive or routinely purchased durable medical equipment
- Expect that we will honor the manufacturer's warranty for equipment purchased from us
- Receive essential information in a language or method of communication that you can understand
- Each patient has a right to have his or her cultural, psychosocial, spiritual, and personal values, beliefs and preferences respected
- To be free from mental, physical, sexual, and verbal abuse, neglect and exploitation
- Access, request an amendment to, and receive an accounting of disclosures regarding your health information as permitted under applicable law

CLIENT RESPONSIBILITIES: As the patient/caregiver, you are RESPONSIBLE for:

- Notifying the company of change of address, phone number, or insurance status.
- Notifying the company when service or equipment is no longer needed.
- Notifying the company in a timely manner if extra equipment or services will be needed.
- Participation as in the plan of care/treatment.
- Notify the company of any change in condition, physician orders, or physician.
- Notifying the company of an incident involving equipment.
- Meeting the financial obligations of your health care as promptly as possible.
- Providing accurate and complete information about present complaints, past illnesses,
- hospitalizations, medications, and other matters pertinent to your health.
- Your actions if you do not follow the plan of care/treatment.

OUR RIGHTS: As your pharmacy of choice, we have the right to:

- Terminate services to anyone who knowingly furnishes incorrect information to our pharmacy to secure medication or durable medical equipment.
- To refuse services to anyone who enters our pharmacy and is threatening, intoxicated by alcohol, drugs and/or chemical substances and could potentially endanger our staff and patients.

FREQUENTLY ASKED QUESTIONS

- HOW ARE MY PRESCRIPTIONS FILLED?
  After receiving prescriptions from the physician, the nursing staff at the facility calls or faxes the prescription to ETPS. A licensed pharmacist reviews the order to check for drug allergies, adverse interactions with other medications, and proper dosing. After several quality assurance checks, your prescription is filled and delivered, and then your medication is distributed by your community caregivers.

- CAN I RECEIVE CREDIT FOR MY UNUSED MEDICATIONS?
  ETPS makes every effort to accept and issue credit for unused medications when legally possible. ETPS will credit back the full cost of unused medications, minus the dispensing cost, for a small restocking fee. These are some of the basic requirements to return unused medications for credit:
  - The medication must be individually packaged and sealed with the manufacturing information on the packaging.
  - Credits cannot be given for medications that were billed to insurance plans or the corresponding co-pays and deductibles billed to you.

- HOW ARE MY MEDICATIONS PAID FOR?
  There are several common methods of payment/coverage for prescription medications in the long-term care environment:
    - Medicare and Medicaid provide some prescription drug coverage
    - Private insurance (example Blue Cross/Blue Shield, etc.)
    - Long Term Care Insurance
    - Prescription Drug cards (including Medicare Part D prescription drug plans)

  Any portion of medication costs not covered by insurance (such as the co-pays) will be the patient's responsibility and will be billed monthly. You are responsible for paying 100% of balance by the due date indicated on the statement. You will not be billed for the portion of costs covered by any insurance.

- WHY ARE SOME MEDICATIONS BILLED TO ME AT FULL PRICE WHEN I HAVE INSURANCE?
  - *Your insurance may have changed*
    - ETPS needs your most recent insurance information to bill accurately. Please contact our pharmacy staff at 833.442.9717 as soon as possible with any changes and updated information.
  - *Your medications are over-the-counter (OTC)*
    - Many insurance plans do not cover OTC (non-prescription) medications. Exceptions are often made for insulin and diabetic supplies.
  - *You haven't met your insurance deductible*
    - Some insurance plans require an annual deductible be met before the insurance will pay. Until you meet the deductible amount, your bill will reflect the pharmaceutical expenses that are your responsibility.
  - *Your medication requires prior authorization from your insurance company*
    - Some medications prescribed by your physician may need to be reviewed by your insurance company before the costs can be covered. If this occurs, ETPS will coordinate directly with your physician and insurance company to ensure your medication or an alternative medication is covered.
  - *Your insurance plan has a restriction*
    - In some cases, your insurance plan might have restrictions that include, but are not limited to:
      - The quantity that can be dispensed for refill orders.
      - How long the pharmacy has to file the claims. Sometimes the insurance plan will not cover a medication if it is dispensed or billed outside of the plan parameters.
    - If there is a restriction on your medication, you are often able to file a claim with your insurance company for direct reimbursement.
  - *You're on a mail-order only prescription plan*
    - If your prescription plan is limited to mail-order medications only, the insurance company may not reimburse the pharmacy for medications dispensed. However, most plans allow a "Long-Term Care Retail Pharmacy Override," in which the insurance plan allows patients residing in a long-term care community to get medications filled at a retail pharmacy. ETPS is happy to assist with this if your plan allows for this.

- Why did the pharmacy send a smaller supply of medication when I received a larger supply before going into a long-term care facility?
    - Long Term Care regulations generally recommend a 30-day supply over larger quantities of medications for safety reasons.
    - The quantity dispensed is determined by the facility and may be less than what you received before going into a long-term care facility.
- How will my drugs be covered if I've applied for Medicaid, but am not yet eligible?
    - Once you have applied for Medicaid and are awaiting eligibility, your payment status is considered "Medicaid Pending". During this time, ETPS will send you or your responsible party a monthly statement of drug charges for payment.
    - Please keep us informed of your application status so that we can bill you correctly. Once you have received your eligibility, ETPS will bill Medicaid directly for the majority of your drugs.
- When will statements mail out?
    - Statements are mailed out the first week of every month.
- Will my statement reflect what my insurance company has paid?
    - Our statements only reflect what you owe after insurance has been applied. This is called your copay. These copays are set by your insurance provider.
- What is post consumption billing?
    - This means we will not bill the patient until all medications have been consumed.

      Example:
        - 4/31/22 – Medication is filled and delivered to facility.
        - 5/12/22 – Patient finishes medication.
        - 5/31/22 – We check insurance and quantities.
        - 6/1/22 – ETPS prints and mails statement with fill date and qty and copays.

A. Notifier: East Tennessee Pharmacy Services

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**_____ listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.