Mid Shore Behavioral Health, Inc.
Maryland Recovery Net
Consumer Support Services
Pharmacy Assistance Request Form

Date:_____

Consumer's County of Origin: _____

PLEASE COMPLETE ALL SECTIONS OF THE FORM AND ENSURE IT IS LEGIBLE. INCOMPLETE FORMS WILL BE DENIED AND RETURNED. PLEASE ALLOW 10 BUSINESS DAYS FOR PROCESSING FOLLOWING RECEIPT OF COMPLETED REQUEST.

Consumer Name:_____ DOB: _____

Address:_____ County: _____

Telephone #:_____ Social Security #:_____

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

Name and Contact information for client's State Care Coordinator (SCC):

_____

Is the consumer actively engaged in a Fee-for-Service Public Behavioral Health System (PBHS) funded Substance Use Disorder-related treatment service? Yes No
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

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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.

Requestor: _____ Agency: _____ Phone: _____

CSA USE ONLY

Medicaid ID Number: _____

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

Authorized Signature: _____ Date: _____

Executive Director, Behavioral Health Coordinator Manager, or Board President Signature: _____

_____

Date: _____

Posted _____ **Consumer File** _____ **Paid Pharmacy**_____
Date Date Date

RVSD 7/20/20

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Substance Use Disorder (SUD) Treatment Verification

1. Name of Consumer: _____
2. Is the consumer currently engaged in SUD-related treatment services?

   Yes No
3. Date of enrollment: _____
4. Name of treating SUD Clinician: _____
5. Signature of SUD Clinician: _____

   Date: _____