Resident Name: _____

THE RIGHT TO CHOOSE YOUR PHARMACY

PHARMACY OPT-OUT

Your community has chosen Guardian Pharmacy of Michigan 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 Guardian Pharmacy of Michigan 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 Guardian Pharmacy of Michigan and would like to "opt-out" or decline the services provided by Guardian Pharmacy of Michigan

By signing this form, you are acknowledging the following:

- You are choosing to use a pharmacy provider that is not Guardian Pharmacy of Michigan
- 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 _____ to order a 7-day supply from Guardian Pharmacy of Michigan at my cost while I arrange to have another provider deliver a full supply of the medication. _____ is obligated by the State of Michigan 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, Guardian Pharmacy of Michigan, please disregard the signature block below. <u>Sign below ONLY if you wish to use a pharmacy other than Guardian Pharmacy of Michigan.</u>

_____

Resident/Responsible Party (Print Name)

_____ _____

Resident/Responsible Party Date

_____ _____

Community Representative Date