GREENVILLE HEALTH SYSTEM
HOSPITAL CASE MANAGEMENT
MEDICATION VOUCHER

Date: _____ **Patient Information :***(affix label here)*

_____ Pending Medicaid Primary
_____ Pending Hospital Sponsorship Primary
_____ Self-Pay
_____ **No** Medicare Part D **plus** Pending Hospital Sponsorship Secondary
_____ VA Primary applicable to week-ends and holidays only

Reason for Medication Assistance Request: _____

Medications found on the Upstate Medical Pharmacy Prescription Drug List will not be covered by the voucher. Patients should be informed that these medications will cost them $3 for a 30 day supply and are eligible for refills.

I HAVE BEEN ADVISED THAT I AM RESPONSIBLE FOR PAYING $3.00 FOR EACH MEDICATION LISTED ON THIS VOUCHER _____
Patient Signature

Allergies: *(list)*_____

MEDICATION	DOSE	QTY	DIRECTIONS
# Of Medications		**X $3.00**	**=Estimated prescription total**

3 DAY LIMIT ON CONTROLLED MEDICATIONS
30 DAY LIMIT ON ROUTINE MEDICATIONS
MEDICATIONS FOUND ON UMP RX DRUG LIST ARE NOT COVERED
REFILLS AND OTC'S ARE NOT COVERED

Prescriber's Name: _____ **Phone Number**: _____

Social Worker/Case Manager: _____ _____
(SIGNATURE) (PRINTED NAME)

_____ _____
(PHONE NUMBER) (PAGER)

- Medications may be picked up **1-2 hours** after receipt of voucher by pharmacy
- Medication Vouchers are valid for **3 days** after the date of discharge
- **Original** prescriptions must be given to the pharmacy in order to receive medications
- Controlled substances must be signed for with proper identification, a **state issued photo ID**
- **Upstate Medical Pharmacy**, Greenville Memorial Hospital, 1st floor adjacent to food court
  Hours: Mon-Fri 7:00AM – 7PM; Sat 9AM – 5PM; Sun CLOSED, phone number: 455-8910

FAX (455-8403) COMPLETED VOUCHER AND PATIENT'S FACE SHEET (RUN ON DATE OF DISCHARGE) TO UPSTATE MEDICAL PHARMACY. **BOTH SHEETS ARE REQUIRED.** INCOMPLETE REFERRALS CANNOT BE PROCESSED. PLACE ORIGINAL IN PATIENT'S MEDICAL RECORD UNDER **DISCHARGE PLANNING TAB.**