PREMIER®

Acro Pharmaceutical Services® | Commcare® Specialty Pharmacy

PREMIER COMPANIES

Self-Pay Acknowledgement

(for use prior to providing services or products not covered by patient's insurance)

I am requesting that the Pharmacy provide the following products and/or services:

_____

I understand that these products and/or services are not covered by my health insurance, and that the Pharmacy may charge me for this service. I agree to be liable for payment for these services.

_____	_____	_____
Patient Name	Pharmacy Name	Prescription Number

_____	_____
Patient Signature	Date