Georgia Transplant Foundation

Enriching Lives Everyday

Election of Pharmacy

I _____(full name) **choose to use** the direct billing process for my post-transplant prescription medications. Prescription medications are supplied by a GTF-approved pharmacy. This process will allow the GTF-approved pharmacy to bill my insurance, Medicare or Medicaid for the cost of my post-transplant prescription medications. The balance or co-pay will then be directly taken from my TFP account. This process will allow me to have my fundraising account directly billed so that I do not have to pay upfront for my prescription medications. It is my responsibility to notify my transplant center that I have chosen this option at the time of transplant. It is my responsibility to monitor this billing process by contacting the pharmacy directly as needed.

I _____(full name) **do not choose** to participate in Direct Billing with any of the Georgia Transplant Foundation's partner pharmacies at this time. I understand that this choice means that I will have to pay for my prescriptions out of pocket at time of refill and be reimbursed from my TFP account at a later time.

_____ _____

Print Name Date

_____ _____

Signature Transplant Date

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