Lifeline Medication Dispenser

Service Request Form

Program Name _____ Program Code _____

Client Type: ☐GSD ☐PP For GSD Clients: Payer ID _____ Sub ID _____

Medication Dispenser Unit Serial # _____ Order ☐PERS ☐PMD Have PERS: ☐Yes ☐No

Subscriber Name _____ Date of Birth _____

Street Address _____ Gender: ☐M ☐F

City _____ State _____ Zip Code _____

Phone with Area Code _____ Time Zone: ☐ATL ☐EST ☐CST ☐MST ☐PST ☐AST ☐HI

Phone Service Type: ☐ Standard ☐ Internet ☐ Unknown

Service Contact Information

Contact Name _____ Phone _____

Special Instructions _____

GSD Clients only: Case Manager _____ Phone _____

Reason for Request

☐ PMD Service Request ☐ PMD Only Retrieval ☐ PMD and PERS Service Request ☐ PMD and PERS Retrieval

Notes _____

_____

Resolution

New Unit Serial # _____

Notes _____

_____

☐ Installer did not handle medications ☐ Schedule displayed on dispenser during loading process is accurate (for service only)

Installer Signature _____ **Date** _____

Subscriber Signature _____ **Date** _____

Caregiver Signature _____ **Date** _____

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To Call In: 1-888-632-3261
Fax Form to: 1-888-632-3267

p/n 0930377, Rev. 01

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