# Split Bill Request

940 Industrial Dr S Ste 102
Sauk Rapids, MN 56379
Phone: 320-230-1050
Fax: 320-230-1051

Date: _____

Submitted By: _____

**Instructions:**

1. Pull the label or write the Rx# and drug name
2. Provide the quantity being sent with the patient
3. Fax to the pharmacy for rebilling

**DISCHARGE DATE:** _____

Resident Name: _____ Date of Birth: _____

| RX# Drug: | Qty |
|---|---|
| RX# Drug: | Qty |
| RX# Drug: | Qty |
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| RX# Drug: | Qty |

Patient Signature: _____

**By signing this form I acknowledge that I am accepting the above medicaitons. I understand that the quantity indicated will be billed to my insurance and that I could receive a bill From Guardian Pharmacy.**