PARTICIPANT AGREEMENT

Participant Name	Address	City,State Zip	Telephone Number
Date of Birth	**Medicare Number**	**Medicare Effective Date**	**Policy number/ Group number**

CONSENT FOR MEDICAL TREATMENT

I hereby authorize Caremark Inc. ("Caremark") to provide products and services as requested by me and/or as authorized by my treating physician or other health care provider contacting Caremark on my behalf. I understand that my physician is solely responsible for diagnosing and prescribing drugs, supplies, and clinical services for my condition and otherwise supervising and controlling my medical care. I have been informed by my physician as to the nature, purpose and risks involved in my therapy, and have consented to its administration.

ASSIGNMENT OF HEALTH PLAN BENEFITS

I hereby assign to Caremark my right to receive payment for all products and services provided by Caremark. This assignment shall cover payment from Medicare and Medicaid programs, all other government sponsored health plans, as well as private insurance and all other health plans. I understand this document constitutes a legally binding assignment and is not a mere authorization to collect benefits on my behalf. In the event payments for products or services provided by Caremark are made directly to me or any third party on my behalf, the payee will endorse to Caremark all checks for such payments.

I understand and agree that I am responsible for the payment of any deductible, copayment, coinsurance, non-covered services and all other sums that may become due for the products or services provided to me by Caremark. If the products or services provided to me by Caremark are not covered by my health plan, or for whatever reason and to whatever extent Caremark does not receive payment from my health plan, I do hereby agree to pay Caremark for the balance in full for any amounts due within thirty (30) days of receipt of an invoice. I understand and agree that Caremark may obtain a copy of my credit report. Any invoice remaining outstanding and unpaid beyond 30 days shall bear interest from the date of invoice at the lesser of one and one-half percent (1 ½%) per month or the maximum rate permitted by law. I further agree to pay all costs and expenses of collection, including reasonable attorney's fees and court costs, incurred by Caremark in the event that any unpaid invoice is referred to an outside agency or an attorney for collection.

CONSENT FOR RELEASE OF PERSONAL HEALTH INFORMATION

I consent to Caremark's use and disclosure of my non-public personal information, including personal health information, necessary to provide products or services, facilitate payment for any claims including Medicare/Medicaid claims for such products or services or conduct health care operations. I hereby authorize my treating physician to receive prescribed medication(s) on behalf of myself or my child and I further consent to (i) all medical personnel releasing to the appropriate Federal or State agency or Caremark any and all records pertaining to my medical history, medical services rendered, or treatment provided that are related to the conditions for which Caremark is providing products, supplies or services to me; (ii) my insurer, health plan or any other third party payer or holder of medical or other information about me to the appropriate Federal/State agency or to their authorized agents or releasing to Caremark any and all information pertaining to my health care coverage for the purpose of establishing my eligibility for benefits or the submission of claims; (iii) Caremark releasing to the appropriate Federal/State or other agency any and all information it may have as necessary for Caremark to provide products, supplies or services or to receive payment of benefits on my behalf or to communicate as necessary with other health care providers regarding medical care provided, or to be provided to me; (iv) Caremark's releasing any and all information to any appropriate Federal/State or other agency it may (have) deem as necessary to facilitate the provision of products, supplies or services by a third party or for my registration in any applicable product registration program required for my treatment; (v) the review of any patient records by, and release of information to, any accrediting body or Federal/State or other agency or for the purpose of utilization review, quality management or data collection and analysis. I understand that this consent shall remain in effect until revoked in writing by me or my legal guardian; and (vi) I authorize my insurance carrier to provide Caremark with all information concerning lifetime and benefit maximums, to include the total dollars that have been paid by my insurance carrier to date.

ADDITIONAL PROVISIONS

I understand that the releases and assignments set forth above can be revoked at any time in writing by me or my legal guardian, except to the extent action has already been taken in good faith in reliance on such releases or assignments. This Agreement contains the entire agreement between Caremark and me relating to the provision of products and services by Caremark. No representation, inducement, promise or agreement, oral or otherwise, express or implied, not embodied herein shall be of any force or effect. Any amendment or addendum to this Agreement must be in writing and signed by both parties. This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors, heirs and assigns.

The undersigned certifies that he/she has read the Participant Agreement provisions consent for medical treatment, assignment of health plan benefits, consent for release of personal health information, additional provisions and received a copy, as well as a copy of the patient rights and patient responsibilities documented on the reverse side of this form and the Medicare supplier standards attached hereto. The undersigned also certifies that he/she is the participant, or is duly authorized by the participant as participant's general agent or guardian to execute the above, and accepts its items.

NOTE: A duplicate copy of this Participant Agreement shall be considered the same as an original.

X____ ____

Participant / Spouse / Guarantor / Guardian Signature Relationship to Participant Date

MEDICARE PART B LIFETIME SIGNATURE

I request that payment of authorized Medicare benefits be made on my behalf to Caremark for any products or services furnished to me by Caremark. I authorize Caremark to release to the Centers for Medicare & Medicaid Services and its agents any information required to act on this request or needed to determine these benefits or the benefits payable for related products or services.

X____ ____

Participant / Spouse / Guarantor / Guardian Signature Relationship to Participant Date

PHARMACIST COUNSELING

I would like to consult with a pharmacist regarding my drug therapy. YES____________ NO____________

PATIENT RIGHTS

A patient receiving Caremark therapy has the right:

- To exercise his/her rights as a patient of Caremark.
- To have the patient's family or guardian exercise the patient's rights when the patient has been judged incompetent.
- To respectful and considerate care with full recognition of his/her dignity and individuality, free from verbal, physical and psychological abuse.
- To have his/her property treated with respect.
- To receive appropriate and professional quality services without discrimination based on race, creed, color, religion, sex, national origin, handicap, sexual preference, age, or advance directive status.
- To know that enrollment in the Caremark program will be based on a reasonable expectation that the medical, nursing, pharmacy, and psychosocial needs associated with the therapy regimen can be adequately met by the supplier providing the services.
- To receive information in a way that he or she can reasonably comprehend.
- To be informed regarding relevant program policies and procedures.
- To receive information necessary to provide an informed consent for care that includes an explanation of all services and/or treatments Caremark is to render and when and how such service/treatments will be provided, before care is initiated.
- To participate in decisions regarding his or her care including input into the plan of care and the discharge plan.
- To make choices about future care through an advance directive and to revoke the advance directive at anytime in accordance with applicable law or regulations.
- To be informed of the function, qualifications and name of any person and/or affiliated agency providing service to the patient.
- To consult with a pharmacist regarding drug therapy.
- To privacy and appropriate confidentiality of records including the right to consent to the release of records to any individual not employed by Caremark except physicians or other medical personnel consulting on his/her medical condition, or in the case of his/her transfer to a health care facility, or as required by law or third party payment contract, or as required by any Federal, State, or Accrediting Body or Agency.
- To examine/obtain records kept by Caremark relating to him/her, unless medically contraindicated as documented and signed by his/her physician.
- To timely service and response to reasonable inquiries.
- To be informed regarding the mechanism Caremark has in place for receiving, reviewing, and resolving patient complaints or grievances and to review the written response explaining the resolution without fear of reprisal.
- To voice grievances about or to recommend changes in services and/or policy and procedures to Caremark staff, the area office representatives of the Department of Health or any outside representative of the patient's choice; free from interference, coercion, discrimination or reprisal.
- To be advised of the availability of the toll-free state home health hotline.
- To be informed regarding charges and payments for services including availability of third party coverage and reimbursement.
- To be referred to alternate services when Caremark is unable to meet all identified needs.
- To be informed of any financial benefit or agreement with an entity or person to which he or she is referred.
- To choose health care providers and the right to communicate with those providers.
- To be notified within a reasonable time of anticipated termination of services or plans for transfer to another agency and continuing care requirements.
- To refuse services and/or treatments after being fully informed of and demonstrating understanding of the consequences of such actions.

PATIENT RESPONSIBILITIES

A patient receiving Caremark therapy is responsible:

- For providing accurate and complete information regarding his/her medical history.
- For notifying Caremark of insurance or policy changes.
- For agreeing to a schedule of services and reporting any cancellation of scheduled appointments.
- For participating in the development and updating of a plan of care.
- For communicating whether he or she clearly comprehends the course of treatment and plan of care.
- For following the plan of care and clinical instructions.
- For reporting problems, unexpected changes in physical condition, rehospitalizations, concerns or complaints.
- For accepting responsibility for his/her actions if refusing treatment or not complying with the prescribed treatment.
- For fulfilling financial obligations for services.
- For respecting the rights of health care providers.

Medicare Supplier Standards

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. An authorized individual (one whose signature is binding) must sign the application for billing privileges.
4. A supplier must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other Federal procurement or nonprocurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site.
8. A supplier must permit HCFA, or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards. The supplier location must be accessible to beneficiaries during reasonable business hours, and must maintain a visible sign and posted hours of operation.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine or cell phone is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier's place of business and all Participants and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.
11. A supplier must agree not to initiate telephone contact with beneficiaries, with a few exceptions allowed. This standard prohibits suppliers from calling beneficiaries in order to solicit new business.
12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items, and maintain proof of delivery.
13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair directly, or through a service contract with another company, Medicare-covered items it has rented to beneficiaries.
15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was filled and rented or sold) from beneficiaries.
16. A supplier must disclose these supplier standards to each beneficiary to whom it supplies a Medicare-covered item.
17. A supplier must disclose to the government any person having ownership, financial or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number, i.e., the supplier may not sell or allow another entity to use its Medicare billing number.
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint and any actions taken to resolve it.
21. A supplier must agree to furnish HCFA any information required by the Medicare statute and implementing regulations.

Please send the completed form to:

CVS Caremark
Attn: Medicare Enrollment
P.O. Box 659529
San Antonio, TX 78265-9529