Rx Access

"Connecting Patients To Resources"

Are you or someone you know struggling to pay for expensive prescription medications?

GET YOUR BRAND NAME PRESCRIPTIONS

for a low monthly advocacy fee

Over 1,000 brand name medications covered!

SHOULD I APPLY?

STEP 1 - Do you spend more than $100 per month on brand name prescription medications?

If YES, keep going!

If NO, stop here. This program will not benefit you at this time.

STEP 2 - Does your household income fall in the general guidelines below?

IF YES, CONGRATULATIONS – You pre-qualify for this program.

Proceed to STEP 3 below

GENERAL GUIDELINES*

Single	$22980
Two person household	$31020
Three person household	$39060
Four person household	$47100
Five person household	$55140

***Household income requirements vary by drug manufacturer.**

HOW DO I APPLY?

STEP 3 - Complete the Patient Information form (2 pages) for each person.

STEP 4 - Complete the Payment Authorization form.

STEP 5 - Mail to: 12676 Rockledge Lane FAX TO: 952-960-2871
Nampa, ID 83686

Your application will be processed as soon as received and your completed forms will be Sent to you ready for signature.

This is not an insurance product and is not affiliated with any Medicare, state or governmental programs.

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Patient Information

ONE PERSON PER APPLICATION. **Please PRINT NEATLY and fill out ALL information for EACH client.** This information is necessary. If you have any questions, please call our office.

Patient Last Name: ____________________________ First: _____________________ Middle: _____________
Address: (No PO Box Numbers) ____ Apt/Lot#: _________
City: ____ State: ___________ Zip Code: _________________
Phone Number: ______________________________________ Alternate Number: ________________________
Email Address: ____

Name of closest relative living near you: _____________________ Their Phone Number: _________________

Marital Status: Single Married Divorced Widowed
Number of People in the Household: 1 2 3 4 Other ___ (please specify)

Gender: Male Female Veteran: Yes No U.S. Resident: Yes No
Date of Birth: _______________________________ Social Security #: __ __ __ - __ __ - __ __ __ __

Do you have Prescription Drug Coverage of any kind? *(Do not include Discount Cards or Programs)* Yes No
Are you enrolled in a Medicare Part D Prescription Drug Plan? Yes No
Company Name: ___________________________ Monthly cost: $_________________
When did you (or will you) enter the Donut Hole? (month/year) ___________________

Have you applied for Low Income Subsidy? Yes No
If yes, were you: Approved Not Approved *(Provide copy)* Waiting

Do you have Health Insurance? Yes No
Check Types: Medicare Medicare Advantage VA Private Insurance
Does this plan include prescription drug coverage? Yes No

MEDICATIONS

So as to ensure we order the correct medications, please list ALL prescription medications you should be taking. Refer to your prescription bottles for exact information and spelling. Use extra page if needed. Please note, **not all medications are covered by Patient Assistance Programs.**

	Drug	Dosage	Frequency	Prescribing Doctor	Limits
1)					
2)					
3)					
4)					
5)					
6)					
7)					
8)					

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Patient Information page 2

PHYSICIAN INFORMATION

Please complete all fields for ALL physicians listed on your Medications list. Use extra page if needed.

Dr. First Name: ______________________________ Last: __________________________________ M.D. / D.O.
Address: (No PO Box Numbers) ____ Suite: ____________
City: ____ State: ____________ Zip: ______________
Phone: ____ Fax: _______________________________________

Dr. First Name: ______________________________ Last: __________________________________ M.D. / D.O.
Address: (No PO Box Numbers) ____ Suite: ____________
City: ____ State: ____________ Zip: ______________
Phone: ____ Fax: _______________________________________

Are you allergic to any medications? Yes No

If yes, please list____

FINANCIAL QUALIFICATION INFORMATION

Individual Pharmaceutical Assistance Programs require the following information for acceptance. If one does not wish to disclose such information we may not be able to complete processing.

Did you file a Tax Return Last Year? Yes No If yes, adj. gross on last year tax return $ ___________

If yes, source of income - Pension, Wages, Interest, Etc.____

If income is lower now, please explain: ____

Do you receive ***Income*** from any of the following sources? If yes, please indicate amount you receive each **month**. You must include ***Income*** for the ***Household***; this includes income from spouses even if only one person is applying. Documentation showing Proof of Income is required for each source.

				Applicant	***Spouse***
Social Security	Yes	No	Monthly Amount	$ _______	$ _______
Pension	Yes	No	Monthly Amount	$ _______	$ _______
Disability	Yes	No	Monthly Amount	$ _______	$ _______
Salary, wages or unemployment	Yes	No	Monthly Amount	$ _______	$ _______
Alimony, Child Support or Other	Yes	No	Monthly Amount	$ _______	$ _______
			TOTAL INCOME	$ _______	$ _______
			TOTAL HOUSEHOLD INCOME	$ ____________	

Please complete all that apply:

Filed for disability Approved *(List amount above)* Not approved Waiting

Filed for Medicaid Approved Not approved *(Provide copy)* Waiting

Unemployed, looking for work

Other, please explain ____

Who is helping with your expenses? ____

Assets: In general, most companies do not ask specific information concerning assets held in order to qualify. If one or more of your medications is manufactured by any of these companies someone will contact you.

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Please print neatly

Payment Authorization

Patient Name(s): ________________________________ **Phone:** __________________

Address: ________________________________ **City:** __________________ **State:** ____ **Zip:** _______

Email: ____ **Other Phone:** _____________________

ENROLLMENT FEE: **You must complete one of the payment options below and your Enrollment Fee must be received for your application to be processed.** Will be processed immediately to your charge or draft account given below.

$55.00 for 1-2 medications **$65.00 for 3 or more medications**

MONTHLY SERVICE FEE: **You must complete one of the payment options below for your application to be processed.** Will begin 30 days from receipt of application.

$55.00 for 1-2 medications **$65.00 for 3 or more medications**

Provide payer information exactly as it appears on statement.

Payer Name: ____ **Phone:** _______________________

Address: ________________________________ **City:** __________________ **State:** ____ **Zip:** _______

Email: ____ **Other Phone:** _____________________

☐ **Credit or Debit Card:** Credit Card Debit Card Prepaid Card

I, ________________________________, hereby authorize ***Rx Access*** to charge my credit card for the Enrollment Fee and Monthly Membership Program Fees as described above.

☐ Visa ☐ MasterCard ☐ Discover American Express

Card Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ Exp Date: ___/___

☐ **Bank Draft:** ☐ Checking *Please Include Voided Check* ☐ Savings *Please Include Deposit Slip*

Pre-Authorization Payment Plan: Authorization to honor withdrawals by Rx Access.

Name of Financial Institution: ____

Routing #: __ __ __ __ __ __ __ __ __ Account #: ___________________________

Monthly Service Fee Payment Date: ☐ 5th ☐ 15th ☐ 25th The 5th will be used if none is selected.

As a convenience to me, I, ________________________, request and authorize Rx Access to charge my account for payments drawn by and payable to ***Rx Access*** as described above, provided there are sufficient funds in my account to pay the same upon presentation. I agree that my rights in respect to each payment shall be the same as if drawn by me and signed personally by me. This authority is to remain in effect until revoked by me in writing at least 14 days prior to the next draft and until you receive notice. I agree, Rx Access will be fully protected in honoring any such check or electronic debit.

Payer Signature: ________________________________ ***Date:*** _________________________

Verbal Authorization Taken From: ___________________________ ***Date:*** ______________

Taken By: ____ ***Date:*** _______________

Cancellation/ Refund Policy: Monthly memberships may be cancelled at any time after enrollment with a minimum of **14 *days*** notice ***in writing*** prior to the next billing cycle. Refunds will be granted to members who fail to qualify for **all** PAP programs and submit denial letters from all pharmaceutical companies involved within **120 days** of enrollment, assuming all information has been provided completely and accurately.

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