PLEASE ONE PERSON PER APPLICATION

Please PRINT CLEARLY or you can access our fill-able application online by going to our website at www.therxhelper.com. Please mail application back to or you can fax forms to **888-233-4354**.

PATIENT INFO

First Name_______________________ Last Name____________________________ Middle Initial ____
Address (**No PO Box!**)____ Apt/Lot #________
City__________________________________ State___________________________ Zip Code_________
Phone (Home) ________________________________ Phone (Mobile) ___________________________
Date of Birth_________________ Social Security #__________________ Best Time to Call __________
Gender: Male __Female__ Marital Status: Single __ Married __ Divorced __ Widowed__

INSURANCE INFO

Do you have prescription drug coverage? (This does not include discount cards/programs) Yes__ No__
Do you have a Medicare Part D Plan? Yes__ No__ If yes, Company Name is _____________________
Monthly Cost of Part D Plan $_______________ Donut Hole will occur (Month/Year)_______________

FINANCIAL INFO (This Information Will Determine Your Eligibility for Qualifying for PAP Assistance)

Did you file a Tax Return last year? Yes__ No__ If yes, the TOTAL income on last return $__________

Please specify each amount you are receiving. If you have a spouse, their income is needed as well. You must be able to provide documentation of this income to qualify.

				Patient	Spouse
Wages	Yes__	No__	Monthly Total	$_________	$__________
Social Security	Yes__	No__	Monthly Total	$_________	$__________
Disability	Yes__	No__	Monthly Total	$_________	$__________
Pension	Yes__	No__	Monthly Total	$_________	$__________
Unemployment	Yes__	No__	Monthly Total	$_________	$__________
Other	Yes__	No__	Monthly Total	$_________	$__________
			Total Amount	$_________	$__________

Total Number of People in Household___** **Total Household Income $_______________

If you have no income, please explain____
____
If your income is lower than last year's Tax Return, please explain_________________________________
____

DOCTORS INFO (If more than three doctors, please attach a separate sheet with additional information)

Dr. First Name____________________ Last Name____________________________ Middle Initial_____
Address____ City, State, Zip____________________
Dr's Specialty_______________________ Phone #____________________ Fax# ___________________

Dr. First Name____________________ Last Name____________________________ Middle Initial_____
Address____ City, State, Zip____________________
Dr's Specialty_______________________ Phone #____________________ Fax# ___________________

Dr. First Name____________________ Last Name____________________________ Middle Initial_____
Address____ City, State, Zip____________________
Dr's Specialty_______________________ Phone #____________________ Fax# ___________________

Please continue on Page 2

Applicant: First Name________________ Last Name_______________ Date of Birth ___________

Please list all medications needing assistance. Please print clearly. Make sure to have correct spelling of your medication. Your prescription bottles will provide you with access to all the information needed to fill out this section. Each medication needs to meet certain qualifications. Not all medications have PAP Assistance Programs.

MEDICATION (If more than nine medications, please attach separate sheet with additional information)

	Name of Medication	Dosage	Directions	Prescribing Doctor	(Advocate Use)
1.	___________________________	__________	____________	_______________________	______________
2.	___________________________	__________	____________	_______________________	______________
3.	___________________________	__________	____________	_______________________	______________
4.	___________________________	__________	____________	_______________________	______________
5.	___________________________	__________	____________	_______________________	______________
6.	___________________________	__________	____________	_______________________	______________
7.	___________________________	__________	____________	_______________________	______________
8.	___________________________	__________	____________	_______________________	______________
9.	___________________________	__________	____________	_______________________	______________

HIPAA RELEASE

I agree to have The Rx Helper and its affiliates provide the services for the sole purpose in obtaining assistance for my prescription medication(s). I also confirm that the information provided in this application is true and correct to the best of my knowledge.

I agree that this release of information will remain in effect until termination of my assistance with "**The Rx Helper**". I understand that I have a right to revoke this authorization by providing written notice to "**The Rx Helper**". However, this authorization may not be revoked if "The Rx Helper", its employees or advocates have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I authorize the release of information including the diagnosis, records; examination rendered to me and prescription assistance information. This information may also be released to:

__ Spouse____
__ Child(ren) ____
__ Other____
__ Information is not to be released to anyone.

Messages

Please call __ home________________ __ work_________________ __ Cell Number: ___________________
If unable to reach me:
__ You may leave a detailed message
__ Please leave a message asking me to return your call
__ ____
The best time to reach me is (*day*) ____________________ between (*time*) _________________________

Name of Applicant: ____
Signature of Applicant: ____
Date: _______________________

If applicable, Legal Representatives sign below: *By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.*

Name of Legal Representative: _____________________________________
Signature of Legal Representative: ___________________________________