PHARMACY ADVANTAGE

Financial Assistance Program Enrollment Form

Phone: (800) 456-2112, ext 5 • Fax: (888) 400-0109

PATIENT INFORMATION

Full Name: _____
DOB: _____
Phone #: _____

Address: _____
_____
Social Security Number: _____ - _____ - _____

DRUG INFORMATION

Name / Strength: _____
Quantity (per month): _____
Indication/ Condition: _____

Monthly Cost (after insurance): _____
Expected Length of Treatment: _____

PRESCRIBER INFORMATION

Name: _____
Specialty: _____
DEA /NPI: _____
Address: _____

Contact Person: _____
Phone: _____
Fax: _____
Date: _____

Gross Monthly Amounts

Salary/Wages $_____
Pension/ Unemployment/ Disability $_____

Social Security $_____
Retirement $_____

Child Support/Alimony $_____
Work Comp $_____

Household members (including self)? (circle one) 1 2 3 4 5 6 7 greater than 7
Total Gross Household Monthly Income: $_____
Total Patient Assets: $_____ (This includes savings/checking, IRA, annuities, stocks/bonds/CDs)
You must attach copy of your most recent U.S. Income Tax Return, i.e. IRS Form 1040, 1040A, 1040EZ, 1099

- ✓ Current Federal tax return (paper or electronic)
- ✓ State tax returns
- ✓ 3 most recent pay stubs & 3 months of bank statements

Insurance Information

Private Drug Coverage	**Yes**	**No**
Medicaid *(provide copy of denial letter)*	**Yes**	**No**
Medicare	**Yes**	**No**
Medicare Part D	**Yes**	**No**
U.S. Resident?	**Yes**	**No**
US Armed Forces Veteran?	**Yes**	**No**
Disabled?	**Yes**	**No**

Name of your Primary Health Insurance

Primary Health Insurance Phone Number

Primary Health Insurance ID Number

Primary Health Insurance GROUP Number

Name of your Prescription Insurance (If different than Health Insurance)

Prescription Insurance Phone Number

Prescription Insurance ID Number

Prescription Insurance GROUP Number

Patient Agreement

I certify that this information is complete and accurate to the best of my knowledge, and that I am unable to afford the medication requested. I understand that additional information may be requested to process this application, but that all medical and financial information will be kept confidential as required by law. I understand that the Product(s) made available to me under this program may be denied to me if I do not fully cooperate with efforts made to verify the information provided in this application, or if I do not take steps to secure alternative means of prescription coverage that are available to me, after I become aware of such alternatives. I certify that I shall not seek reimbursement for any medication dispensed as part of this program.

I hereby authorize Pharmacy Advantage to obtain and disclose information from physicians, insurance companies and other information as necessary to verify the information provided in this application although Pharmacy Advantage is not obligated to verify any of the information contained above or confirm other medications that I am taking.
I authorize Pharmacy Advantage to enroll me in (or apply on my behalf for) non-profit organization programs addressing the needs of individuals with insurance who cannot afford their copayments, coinsurance, and premiums for important medical treatments, pharmaceutical company-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to, injection training. I further authorized Pharmacy Advantage to release and communicate the minimum necessary information about my health condition and prescription(s) to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis and provide educational information regarding therapies.

I understand I may revoke this authorization at anytime in writing by sending a letter to Pharmacy Advantage, 735 John R Suite 150, Troy, MI 48083.
I hereby authorize the release of the information contained in this application to Pharmacy Advantage for the determination of my eligibility status for financial assistance in accordance with the policies and procedures. I authorize Pharmacy Advantage to verify this information as necessary, which may include but is not limited to, obtaining a credit bureau report, employment and/or income verification, and appropriate supporting documents.

All information and income documentation provided by me in this application is true, accurate and complete as shown. If it is determined at any time the information I provided was false or inaccurate, all financial assistance will be reversed, and I will accept responsibility for full and immediate payment of any and all outstanding balances. I also agree to accept payment responsibility for any amount due after any partial financial assistance discounts are applied.
I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. However, I will not be enrolled in the service program listed above. A copy of this authorization will be utilized with the same effectiveness as an original.

Patient Signature: _____ **Date** _____