

1129

Membership Enrollment Form

Enrollee Information

Name: _____ Address: _____
 City: _____ State: _____ Zip: _____ Home Phone: _____
 Marital Status: _____ Date of Birth: _____ S.S.# _____

The best time to contact me during the week is in the: **Morning** **Afternoon** (*check one*) **Male** **Female**

Alternate Contact Information (*Contact this person if unable to contact me two consecutive days*)

Name: _____ Home Phone: _____
 Relationship to Patient: _____ Work Phone: _____

Physician Information (*Only list those doctors who prescribe medications listed below*)

Doctor #1

Doctor #2

Name: _____	Name: _____
Facility Name: _____	Facility Name: _____
Address: _____	Address: _____
Suite: _____ City: _____	Suite: _____ City: _____
State: _____ Zip: _____	State: _____ Zip: _____
Office Phone: _____	Office Phone: _____

Prescription Information (*Please put the prescribing doctor # with each medication*)

Dr. #	Brand/Generic	Strength	Frequency

AUTHORIZATION AGREEMENT FOR AUTOMATIC PAYMENTS

I want to pay my \$95 monthly membership fee by the method checked below:

BANK DRAFT (you must attach a copy of your voided check)
 Authorized Signature **X** _____
 CREDIT CARD Visa MasterCard Discover Am. Ex.
 Card # _____ 3 Digit Sec. Code _____
 Exp. Date _____ Authorized Signature **X** _____

Please check ONE payment option
 Bank Draft – funds deducted from your checking or savings account
 Credit Card – funds charged to the indicated credit card company

DEDUCTION AUTHORIZATION: I authorize PAS, or its designated attorney-in-fact, to electronically draft my above account for my membership fees. This authorization is to remain in full force and effect until PAS has received written notification from me of its termination in such a time and manner to afford PAS, their designated administrator and depository a reasonable opportunity to act on it.

Signature **X** _____ Today's Date _____

Dear Patient Assistance Services:

I have completely filled out and am submitting the Membership Enrollment Form along with this contract. Please process it and coordinate all available medications prescribed by my doctor with all applicable membership services available to me.

I do meet the below GENERAL GUIDELINES for the pharmaceutical companies' Patient Aid Programs:

Gross yearly family income is less than \$31,000 or gross single income is less than \$19,000. Total Gross Taxable Income includes: wages, social security, pension, disability, interest earnings, etc AND currently, have no coverage (insurance or government program) that reimburses or pays for prescription medications.

I understand, agree and authorize PAS, Inc.:

- ✓ that not all medications I am taking may be available through the pharmaceutical companies *free* drug programs.
- ✓ that pharmaceutical companies have certain criteria that must be met and that the *pharmaceutical companies will make the final decision as to who qualifies for their programs.*
- ✓ that I will receive a telephone (qualification) call from PAS to initiate qualifying me for the pharmaceutical companies' programs, and that when qualified, *I will be required to provide proof of my income with my first membership payment before any membership services will occur on my behalf.*
- ✓ that the enclosed *non-refundable* \$25 enrollment fee and the first monthly membership fee must be included.
- ✓ that once applications have been completed by PAS, they will be mailed to my doctor for his/her signature. The doctor will then mail them back to PAS so they may be forwarded to the appropriate pharmaceutical company(s). *PAS cannot be held responsible if the applications are not returned by the doctor.*
- ✓ that once the signed applications for the pharmaceutical companies PAPs (free drug programs) are returned to PAS it may take 4-6 weeks before I receive my first shipment of medications (generally a 90 day supply).
- ✓ that the pharmaceutical company determines whether my medication is shipped to my physician, picked up at a local pharmacy, or shipped directly to my home. *Members or PAS cannot decide where medications are to be delivered.*
- ✓ that I am authorizing the alternate contact, ***if filled-in***, on the Membership Enrollment Form be approved to act on my behalf with regards to my account/records with PAS.
- ✓ I may cancel my membership at any time, but no refund will be issued as benefits are established on a quarterly basis.
- ✓ that, with regard to the pharmaceutical companies Patient Aid Programs, PAS acts only as a processing assistant to help me apply for and complete applications necessary to receive free drugs offered by pharmaceutical companies; *PAS does not manufacture drugs, prescribe drugs, dispense drugs, recommend medication, or evaluate prescriptions.*

I authorize PAS, Inc. or its affiliates to act as my authorized patient advocate representative and hereby give them authority to sign any/all forms and applications on my behalf with regard to the pharmaceutical companies' Patient Aid Programs.

I authorize PAS, Inc. or its affiliates to access and release any/all personal, medical and financial information requested that relates to the pharmaceutical companies' application/renewal process relevant to their Patient Aid Programs. *By signing this form, I authorize PAS, Inc. or its affiliates to sign any/all HIPAA related forms on my behalf.*

I attest that the information provided in this application is complete and accurate. By my signature, I authorize Patient Assistance Services, Inc. to request and obtain from my healthcare provider, insurance company, or pharmaceutical company/manufacturer or its contractors any of my medical records and information, financial and insurance records and information, and/or any other information necessary for the purpose of verifying the accuracy of the information provided in this application or related to my enrollment or participation in the various pharmaceutical patient assistance programs (PAPs). I understand that any such information obtained, as well as the information provided to me in this application, will be used by Patient Assistance Services, Inc. and its authorized agent(s) solely to administer the PAPs and those services provided only by Patient Assistance Services, Inc., but will not be used or disclosed for any other purposes, except as may be required by applicable law. I understand that neither Patient Assistance Services, Inc. nor my healthcare provider may be held responsible in the event I provide information deemed to be fraudulent.

Name _____

\$120 Due With This Enrollment Form
(Enrollment Fee and 1st Month Membership)

Signature **X** _____

Today's Date _____

Mail Completed Enrollment Form To:

Patient Assistance Services, Inc. – P.O. Box 407 – Marion, OH 43301-0407 – 1-877-463-1905