



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.

	Yes ___ No ___	Monthly Total	Patient	Spouse
Wages	Yes ___ No ___	\$ _____	\$ _____	\$ _____
Social Security	Yes ___ No ___	\$ _____	\$ _____	\$ _____
Disability	Yes ___ No ___	\$ _____	\$ _____	\$ _____
Pension	Yes ___ No ___	\$ _____	\$ _____	\$ _____
Unemployment	Yes ___ No ___	\$ _____	\$ _____	\$ _____
Other	Yes ___ No ___	\$ _____	\$ _____	\$ _____
		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: _____