

ENROLLMENT FORM INSTRUCTIONS:

REF. # _____

Please respond to ALL sections and provide your original signature. The information should be completed by applicant or legal representative. **PASS PROTECTS YOUR PRIVACY.** This information is required by the pharmaceutical companies for you to qualify for its Patient Assistance Programs. PASS will never share this information with any other person or entity.

1. PERSONAL INFORMATION



Applicant Information:

<input type="text"/>	<input type="checkbox"/>	<input type="text"/>
First Name	M	Last Name

<input type="text"/>
Address

<input type="text"/>	<input type="checkbox"/>	<input type="text"/>
City	ST	Zip Code

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Telephone	Secondary Phone No.	Gender	<input type="checkbox"/> M <input type="checkbox"/> F

<input type="text"/>	<input type="text"/>
Social Security No.	Date of Birth

Marital Status: Single Divorced Widowed Married # in Household (Include self) _____

Are you a U.S. citizen?: Yes No Spouse's Name _____

Are you enrolled in Medicare? Yes No

Are you enrolled in Medicaid?: Yes No If not, are you eligible for Medicaid?: Yes No

Secondary Contact:

Please provide this information if you would prefer calls, correspondence and invoices directed to someone not living at applicant's address.

First Name: _____ Middle Initial: _____ Last Name: _____

Street Address: _____ Apt. #: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Secondary Phone: _____

Relationship to Applicant: _____

2. FINANCIAL INFORMATION

If Single, provide Total Annual Household Income: \$ _____

If Joint/Family, provide Total Annual Household Income: \$ _____

(NOTE: Total income includes Wages, Social Security, Pension, Disability, Interest Earnings)

List Income Sources:

Assets	Total Value	Monthly Earnings	Gross Monthly Income	Applicant/Spouse (other)
Stocks/Bonds			Salary/Wages	/
CDs			Pension	/
Savings			Social Security	/
Checking			Disability	/
IRA			Unemployment	/
Annuities			Other	/
Other				

3. INSURANCE INFORMATION

Do you have prescription coverage in a government or private program? Yes No

If yes, check all that apply: Medicare Medicaid State Program Veterans Administration Other

If other, please complete:

Insurance Carrier: _____

Phone #: _____ Address: _____

Policy ID #: _____ Group #: _____

If covered in a government or private program, have you exhausted all drug coverage limits? Yes No

If covered, is a particular medication not covered under the drug policy? Yes No

If yes, please name medication(s): _____

4. MEDICAL INFORMATION

Medically Diagnosed Conditions: (Please check all that apply.)

None Allergies Arthritis Asthma Depression/Anxiety Diabetes Gastrointestinal

Glaucoma Heart High Blood Pressure High Cholesterol Osteoporosis

List others: _____

List Allergies: (Please check all that apply.)

None Acetaminophen Alcohol Ampicillin/Amoxicillin Aspirin Cephalosporin Antibiotics

Codeine Iodine Penicillin Propoxyphene Sulfa Tetracyclines

List others: _____

List Current Prescription Medications: Please list all medications that you would like to have filled through the PAP.

If necessary, include any other additional medications on an attached sheet.

Brand/Generic Name	Strength	Frequency (i.e., 2 pills 3 x per day)	Prescribing Physician

5. Physician Information

Provide only the names of physicians who prescribe the medications listed above:

Physician Name: _____ Facility Name: _____

Street Address: _____ Suite #: _____

City: _____ State: _____ ZIP: _____

Designation: MD DO IM PA Office Phone: _____

Specialty: _____ Office Fax: _____

Provide the names of any additional physicians who prescribe medications. If necessary, include an additional sheet:

Physician Name: _____ Facility Name: _____

Street Address: _____ Suite #: _____

City: _____ State: _____ ZIP: _____

Designation: MD DO IM PA Office Phone: _____

Specialty: _____ Office Fax: _____

Total average monthly medical expenditures that are NOT reimbursed by insurance, Medicare or Medicaid:

Physicians: \$ _____ Lab/Other: \$ _____ Prescriptions: \$ _____

If a pharmaceutical Patient Assistance Program allows a choice of where the approved medications can be shipped,

please indicate your preference: Residence Physician's Office

6. Select Your PASS Payment Options

Enrollment Fee - \$25:

This one-time fee entitles you to enrollment in the PASS program. This fee is 100% refundable if PASS determines your personal information or prescription medications make you ineligible for available Patient Assistance Programs.

Enclosed is my check or money order made payable to PRL, Inc. for \$25.

Please bill my credit or debit card for \$25. Be sure to provide current credit card information in section #7.

Monthly Standard Service Fee - \$30 for each approved medication - per month:

If approved with one or more medications, please enclose the first month's fees and check below how you would prefer to pay your monthly service fee per medication - per month:

Via monthly charge of \$30 per approved medication to my credit or debit card (Visa, MasterCard, Discover, American Express)

Via monthly automatic draft from my bank account of \$30 per approved medication.

(NOTE: Agreement and forms to process monthly payment options will be sent separately.)

Please bill me \$30 monthly fir each eligible medication.

7. Payment Information



Enclosed is a check or money order made payable to PASS for \$25 enrollment fee - and \$30 monthly service fee per medication - per month.

Please charge my credit or debit card: Visa MasterCard Discover American Express

Name as it appears on credit/debit card:

First Name

M

Last Name

Credit Card Number

*
Security Code*

/
Mo. / Year

Card Expiration Date

* Security Code: 3-Digit code on back of card (4-Digit for American Express) by the signature space.

Mail this application and payment in the postage-paid envelope to: 2550 CrossTimbers Road, Suite 116-199, Flower Mound, TX 75028

8. PASS Applicant Agreement and Authorization

I and Prescription Assistance Specialized Services (PASS) understand and agree to the following terms:

1. Each pharmaceutical company offering a Patient Assistance Program: 1) has established its own criteria in qualifying candidates for participation; 2) may grant or deny approval on a case-by-case basis with no eligibility guidelines available to the public; and 3) makes final determination of eligibility at its sole discretion. Therefore, PASS does not guarantee approval with any Patient Assistance Program offered by any pharmaceutical company.
2. PASS has established general criteria to assist in determining the individuals most likely to qualify for Patient Assistance Programs. The guidelines formulated by PASS do not guarantee my eligibility or approval for participation in any Patient Assistance Program.
3. Not all prescription medications are covered through Patient Assistance Programs. Each pharmaceutical company determines the prescription medications that it covers under its Patient Assistance Program.

My Personal Information and Documentation:

4. I will provide PASS with truthful, accurate, and complete information and documentation as deemed necessary to complete the application process with any applicable Patient Assistance Program.
5. PASS will not be responsible to me or to any other person or entity if I fail to provide PASS or the pharmaceutical company with truthful, accurate, and complete information and documentation as required by any applicable Patient Assistance Program.
6. Written proof of income and insurance status (when applicable) may be required by any Patient Assistance Program. PASS does not establish requirements of proof. Proof required may include a copy of one or all of the following: Internal Revenue Service Form SSA-1099; most recently filed federal income tax return (Form 1040/1040-A); and/or IRS Form 4506-T for verification of non-filing or other tax status; and/or one month of consecutive pay stubs. At times, applicable Patient Assistance Programs may require additional documents for qualification purposes.

