ENROLLMENT FORM
$50 PER MONTH PER MEDICATION

Prescription Hope
Unmatched Rx Savings

No Enrollment Fees, No Application Fees, No Hidden Costs

PERSONAL INFORMATION | One form per person. Please print clearly.

First Name		Middle Initial		Last Name	
Date of Birth	/ /	Sex	F ☐ M ☐	SSN	- -
Address				City	
State		ZIP Code		Phone	( ) -
Fax	( ) -				
E-mail				Number of people in household	
Alternate Contact				Alternate Contact Phone	( ) -

Marital Status	SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐	Employment Status	FULL TIME ☐ PART TIME ☐ RETIRED ☐ UNEMPLOYED ☐

A. Are you a US Citizen?	YES ☐ NO ☐	B. Are you disabled as determined by Social Security?	YES ☐ NO ☐
C. Are you on Medicare?	YES ☐ NO ☐	D. Do you have Medicare Part D?	YES ☐ NO ☐
E. Have you applied for Medicaid?	YES ☐ NO ☐	F. Have you applied for low-income subsidy? (LIS)	YES ☐ NO ☐

If you answered YES to questions E. or F., please send a copy of the determination letter with this form.

How did you hear about Prescription Hope? Please be specific.	

DOCTOR(S) INFORMATION | Only list doctors who prescribe medication(s) for you. Please print the doctor's full mailing address.

Doctor 1		Doctor 2	
Facility Name		Facility Name	
Address/Suite		Address/Suite	
City/State/Zip		City/State/Zip	
Phone ( ) -	Fax ( ) -	Phone ( ) -	Fax ( ) -

MEDICATION INFORMATION | Please only list medications that you need assistance with.

Doctor 1 or 2	Medication Name	Strength	Frequency (ex. take once daily)

MONTHLY HOUSEHOLD INCOME

Gross Salary/Wages	$	Pension	$	SS Retirement*	$
Unemployment	$	Annuity/IRA	$	SS Disability*	$

*If you are on Medicare, please send a copy of your most recent Social Security New Benefit Amount Statement with this form.

If you do not have your most recent Social Security Statement, you can request one by calling the Social Security Administration at 1.800.772.1213.

Please sign here if you currently have no income ➤		Please sign here if you do not file a tax return ➤	

ELECTRONIC PAYMENT INFORMATION | Please check the box and provide information for the payment method you would like to use.

If this section is not complete, we cannot process your enrollment form.

VISA ☐ MasterCard ☐ AMERICAN EXPRESS ☐ DISCOVER ☐

Debit/Credit Card Account Number (16 Digits - 15 Digits For AMEX Card Holders):

Expiration Date: Month/Year ☐☐ / ☐☐

CVV Option 1* (Visa, Mastercard, and Discover Card Holders) ☐☐☐ *3-digit number printed on the back of your card

CVV Option 2** (AMEX Card Holders) ☐☐☐☐ **4-digit number printed on the front of your card

POLICIES | Please read all policies and initial in the designated boxes.
If you do not initial ALL boxes, we cannot process your enrollment form.

Fees: During the initial enrollment process if we find that we are unable to assist you with at least one medication, there will be no charges to your account. If we are able to assist you with one or more medication(s), the first month's administrative service fee of $50 per medication will be debited only for the medication(s) for which we can assist you upon receipt of this form. The monthly administrative service fee of $50 per medication will be debited on the 5th day of every month thereafter unless the 5th falls on a weekend or a holiday, in which case the debit will occur on the prior business day. You will be notified in writing of the medication(s) for which we are able to assist you. There are no other fees for the program or cost for the medication(s). It will take approximately 4-6 weeks to start receiving your first supply of medication(s). This range is an average amount of time and is contingent upon a prompt response to the information we request from you and your physician(s). The medication is shipped directly from the pharmaceutical companies and delivered either to your home or physician's office, depending upon the manufacturer delivery guidelines. You hereby acknowledge that you are not paying for medication(s) through the Prescription Hope service; rather you are paying for the administrative service of ordering, managing, tracking and refilling medications received through Prescription Hope's medication advocacy service from pharmaceutical company patient assistance programs. You hereby authorize Prescription Hope and/or its agents to debit the account provided on the front of this form for all administrative service fees described in this Fees section. You also agree to pay any associated fees should your EFT (electronic fund transfer) be returned unpaid by your financial institution. Due to the service-based nature of the Prescription Hope service, there are no refunds other than what is explained in the Prescription Hope Guarantee below. You hereby acknowledge, consent and agree this agreement is for twelve (12) months commencing on the date you sign below and will automatically be renewed for twelve (12)-month terms thereafter. You may terminate this agreement at any time by providing a signed letter of cancellation. Cancellations can take up to 30 days to process. Service fees will continue to be assessed until medication supplies deplete. Upon termination you agree to be financially responsible for any outstanding balances. This monthly transaction will appear on your billing statement as "PRESCRIPTION HOPE." You agree that you may be contacted via telephone, cellular phone, text message or email through all numbers/addresses provided by you and authorize receipt of pre-recorded/artificial voice messages and/or use of an automated dialing service by Prescription Hope or affiliates. By signing below, you further agree to release Prescription Hope, its agents, employees, successors and assigns from any and all liability including legal fees and costs arising from medications taken by you which were procured through the Prescription Hope medication advocacy service and/or your reliance upon the program in general. You further agree to indemnify and hold Prescription Hope, its agents, employees, successor and assigns harmless against any and all damages including legal fees and costs arising from third persons ingesting any medication procured for you through the Prescription Hope advocacy program.

By initialing here you acknowledge that you have read, understood and agree to be bound by the above paragraphs. ➤ _____

Service: You hereby authorize Prescription Hope to act on your behalf and to sign applications for patient assistance programs by hereby granting to Prescription Hope a limited power of attorney for the specific purposes of enrolling you in patient assistance programs with the applicable pharmaceutical companies and any related activities to process your enrollment. You understand this authorization can be revoked at any time by you by providing a signed letter of cancellation to Prescription Hope as described in the fees section. You hereby authorize your physician's office(s) to discuss/release medical information to Prescription Hope relating to your application(s) for patient assistance programs that Prescription Hope is processing on your behalf. You understand that Prescription Hope does not ship, prescribe, purchase, sell, handle or dispense prescription medication of any kind in its efforts to process your application(s) for patient assistance programs. Prescription Hope is a fee-based medication advocacy service that assists patients in enrolling in applicable pharmaceutical companies' patient assistance programs. The medications themselves are offered by the pharmaceutical companies through their patient assistance programs at no cost to the eligible applicant. You also understand and acknowledge that it is each individual pharmaceutical company who makes the final decision as to whether you qualify for their assistance program(s). You understand Prescription Hope reserves the right to rescind, revoke, or amend its services at any time. Prescription Hope does not guarantee your approval for patient assistance programs; it is up to each applicable drug manufacturer to make the eligibility determination. Each drug manufacturer independently sets its own eligibility criteria and determines which products are included in their assistance programs. Medications covered are subject to change at any time. Prescription Hope assembles and submits your application to the pharmaceutical company but does not participate in the review process to determine which applicants are eligible.

By initialing here you acknowledge that you have read, understood and agree to be bound by the above paragraphs. ➤ _____

Guarantee: If you do not receive medication because you were determined to be ineligible for the patient assistance program by the applicable pharmaceutical manufacturer(s) and you have a letter of denial, Prescription Hope will gladly refund the monthly administrative service fee(s) for the medication(s) determined to be ineligible. All Prescription Hope needs from you is a copy of the denial letter sent to you from the applicable drug manufacturer explaining why you are ineligible.

Privacy: We value our patients and make extreme efforts to protect the privacy of our patients' personal information. Patient information is processed for order fulfillment only and for no other purpose. Patient information, including all patient health information and personal information, will never be disclosed to any third party under any circumstances. All information given to Prescription Hope, Inc., its agents, employees, successors and assigns (collectively, "Prescription Hope") will be held in the strictest confidence.

Eligibility: You are experiencing hardship in affording your medication and/or you currently do not have coverage that reimburses or pays for your prescription medications. You affirm that the information provided on this form is complete and accurate. If you determine the information was not correct at the time you provided it to Prescription Hope, or if the information was accurate but is no longer accurate, you will immediately notify Prescription Hope in writing by providing the correct information.

By initialing here you acknowledge that you have read, understood and agree to be bound by the above paragraphs. ➤ _____

NOTE **DO NOT DELAY TAKING REQUIRED PRESCRIPTION MEDICATION WHILE YOU WAIT FOR PRESCRIPTION HOPE TO PROCESS YOUR ENROLLMENT FORMS FOR PATIENT ASSISTANCE PROGRAMS, AS THE APPROVAL PROCESS CAN TAKE APPROXIMATELY 4 TO 6 WEEKS. PRESCRIPTION HOPE IS NOT RESPONSIBLE FOR ANY ADVERSE HEALTH CONSEQUENCES THAT MAY RESULT DUE TO A DECISION TO DELAY TAKING YOUR REQUIRED PRESCRIPTION MEDICATION IN RELIANCE UPON THE PRESCRIPTION HOPE MEDICATION ADVOCACY SERVICE.**

Please sign here ➤ _____

Date _____

You will be notified in writing of the medication(s) we can help you with.

Please mail or fax this entire, completed application to Prescription Hope at:

MAIL	FAX
Prescription Hope, Inc. P.O. Box 2700 Westerville, Ohio 43086	1-877-298-1012