ENROLLMENT FORM
$50 PER MONTH PER MEDICATION

No Enrollment Fees, No Application Fees, No Hidden Costs

Prescription Hope
Unmatched Rx Savings

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.

Service: Prescription Hope, Inc. is a fee-based medication advocacy service that assists patients in enrolling in applicable pharmaceutical companies' patient assistance programs. You hereby authorize Prescription Hope, Inc. to act on your behalf and to sign applications for patient assistance programs by hereby granting to Prescription Hope, Inc. a limited power of attorney for the specific purposes of enrolling you in patient assistance programs 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, Inc. as described in the Fees section. You hereby authorize your healthcare provider's office to discuss/release medical information to Prescription Hope, Inc. relating to your applications for patient assistance programs that Prescription Hope, Inc. is processing on your behalf. You understand that Prescription Hope, Inc. does not ship, prescribe, purchase, sell, handle, or dispense prescription medication of any kind. The pharmaceutical companies offer the medication through patient assistance programs at no cost. You hereby acknowledge that you are not paying for medication(s) through the Prescription Hope, Inc. service; rather you are paying for the administrative service of ordering, managing, tracking, and refilling medications received through the Prescription Hope, Inc. medication advocacy service. You also understand and acknowledge that it is each individual pharmaceutical manufacturer who makes the final decision as to whether you qualify for their patient assistance programs.

You understand Prescription Hope, Inc. does not guarantee your approval for patient assistance programs; it is up to each applicable drug manufacturer to make the eligibility determination. You will be provided details in writing for each of your eligible medications. The medication is shipped directly from the pharmaceutical company and is delivered either to your home or healthcare provider's office, depending upon the manufacturer delivery guidelines. You agree that you may be contacted via telephone, cellular phone, text message or email through all numbers and/or addresses provided by you and authorize receipt of pre-recorded and/or artificial voice messages and/or use of an automated dialing service by Prescription Hope, Inc. and/or its affiliates. By signing below, you further agree to release Prescription Hope, Inc., its agents, employees, successors and assigns from any and all liability including legal fees and costs arising from medication(s) taken by you which were procured through the Prescription Hope, Inc. medication advocacy service and/or your reliance upon the program in general. You further agree to indemnify and hold Prescription Hope, Inc., 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 Prescription Hope, Inc. Medications covered are subject to change at any time. Prescription Hope, Inc. reserves the right to rescind, revoke, or amend its services at any time.

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 a patient assistance program and you have a letter of denial by the applicable pharmaceutical manufacturer, Prescription Hope, Inc. will refund the monthly administrative service fee for the medication determined to be ineligible. All Prescription Hope, Inc. will need 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, Inc.") will be held in the strictest confidence.

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

Fees: Prescription Hope, Inc. charges a service fee of $50 per month for each medication. The monthly service fee covers 100% of the medication cost, as well as the services provided by Prescription Hope, Inc. There are no additional costs for the medication(s). If we find that we are unable to access at least one of your medication(s) during the initial enrollment process, there will be no charges to your account. If we can access your medication, the initial service fee will be debited immediately so we can begin processing the paperwork required to order each eligible medication. The initial processing of your medication order(s) ranges from an average of 4 to 6 weeks and is contingent upon prompt responses to information that we request from you and your healthcare provider(s). Prescription Hope, Inc. will process your monthly service fee on the same day each month corresponding to your enrollment date. This monthly transaction will appear on your statement as "PRESCRIPTION HOPE". 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 Prescription Hope, Inc., there are no refunds other than what is explained in the Prescription Hope, Inc. Guarantee above.

You hereby acknowledge, consent, and authorize this agreement is for twelve months commencing on the date you sign below and will automatically be renewed for twelve-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(s) supplies deplete. Upon termination, you agree to be financially responsible for any outstanding balances.

Eligibility: You are experiencing a hardship with 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, Inc., or if the information was accurate but is no longer accurate, you will immediately notify Prescription Hope, Inc.

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**