

Preferred Prescription Assistance

a division of Preferred Hospital Group, LLC



The Spirit of Serving

Are you or someone you know struggling to pay for prescription medications?

GET YOUR BRAND NAME PRESCRIPTIONS FREE

**for the low monthly handling fee of \$50!
(even if you have Medicare)**

Over 1,000 brand name medications covered!

SHOULD I APPLY?

STEP 1 - Do you spend more than \$50 per month on prescription medications?

If YES, keep going!

If NO, stop here. This program will not benefit you at this time.

STEP 2 - Does your household income fall in the general guidelines below?

IF YES, CONGRATULATIONS – You pre-qualify for this program.

Proceed to STEP 3 below

IF NO, stop here. You do not qualify for this program at this time.

GENERAL GUIDELINES*

Number of People in Your Household	Estimated Total Household Income
You ☺	Less than \$20,800 a year
You + 1 ☺ ☺	Less than \$28,000 a year
You + 2 ☺ ☺ ☺	Less than \$35,200 a year
You + 3 ☺ ☺ ☺ ☺	Less than \$42,400 a year
Add this amount for each additional person	\$7,200 a year

***Household income requirements vary by drug manufacturer.**

HOW DO I APPLY?

STEP 3 - Complete the Patient Information form (2 pages) for each person.

STEP 4 - Complete the Payment Authorization form.

**STEP 5 - Mail to: 2020 Fieldstone Pkwy, Suite 900 #245 or Fax to: (615) 250-4844
Franklin, TN 37069**

Your application will be processed as soon as received and your completed forms will be sent to you ready for signature.

Got questions? Call the Patient Assistance Center toll-free at (877) 445-6009

This is not an insurance product and is not affiliated with any Medicare, state or governmental programs.

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Patient Information

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ONE PERSON PER APPLICATION. Please PRINT NEATLY and fill out ALL information for EACH client. This information is necessary. If you have any questions, please call our office.

Patient Last Name: _____ First: _____ Middle: _____
Address: (No PO Box Numbers) _____ Apt/Lot#: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____ Alternate Number: _____
Email Address: _____

Name of closest relative living near you: _____ Their Phone Number: _____

Marital Status: Single Married Divorced Widowed

Number of People in the Household: 1 2 3 4 Other ____ (please specify)

Gender: Male Female Veteran: Yes No U.S. Resident: Yes No

Date of Birth: _____ Social Security #: _____ - _____ - _____

Do you have Prescription Drug Coverage of any kind? (Do not include Discount Cards or Programs) Yes No

Are you enrolled in a Medicare Part D Prescription Drug Plan? Yes No

Company Name: _____ Monthly cost: \$ _____

When did you (or will you) enter the Donut Hole? (month/year) _____

Have you applied for Low Income Subsidy? Yes No

If yes, were you: Approved Not Approved (Provide copy) Waiting

Do you have Health Insurance? Yes No

Check Types: Medicare Medicare Advantage VA Private Insurance

Does this plan include prescription drug coverage? Yes No

MEDICATIONS

So as to ensure we order the correct medications, please list ALL prescription medications you should be taking. Refer to your prescription bottles for exact information and spelling. Use extra page if needed. Please note, **not all medications are covered by Patient Assistance Programs.**

Manufacturer (Producer Use)	Drug	Dosage	Frequency	Prescribing Doctor	Limits (Producer Use)
1)	_____	_____	_____	_____	_____
2)	_____	_____	_____	_____	_____
3)	_____	_____	_____	_____	_____
4)	_____	_____	_____	_____	_____
5)	_____	_____	_____	_____	_____
6)	_____	_____	_____	_____	_____
7)	_____	_____	_____	_____	_____
8)	_____	_____	_____	_____	_____

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Patient Information page 2



PHYSICIAN INFORMATION

Please complete all fields for ALL physicians listed on your Medications list. Use extra page if needed.

Dr. First Name: _____ Last: _____ M.D. / D.O.
Address: (No PO Box Numbers) _____ Suite: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Dr. First Name: _____ Last: _____ M.D. / D.O.
Address: (No PO Box Numbers) _____ Suite: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Are you allergic to any medications? Yes No

If yes, please list _____

FINANCIAL QUALIFICATION INFORMATION

Individual Pharmaceutical Assistance Programs require the following information for acceptance. If one does not wish to disclose such information we may not be able to complete processing.

Did you file a Tax Return Last Year? Yes No If yes, income on last year tax return \$ _____

If yes, source of income - Pension, Wages, Interest, Etc. _____

If income is lower now, please explain: _____

Do you receive **Income** from any of the following sources? If yes, please indicate amount you receive each **month**. You must include **Income** for the **Household**; this includes income from spouses even if only one person is applying. Documentation showing Proof of Income is required for each source.

				<i>Applicant</i>	<i>Spouse</i>
Social Security	<input type="checkbox"/> Yes <input type="checkbox"/> No	Monthly Amount	\$ _____	\$ _____	
Pension	<input type="checkbox"/> Yes <input type="checkbox"/> No	Monthly Amount	\$ _____	\$ _____	
Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	Monthly Amount	\$ _____	\$ _____	
Salary, wages or unemployment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Monthly Amount	\$ _____	\$ _____	
Alimony, Child Support or Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	Monthly Amount	\$ _____	\$ _____	
		TOTAL INCOME	\$ _____	\$ _____	
		TOTAL HOUSEHOLD INCOME	\$ _____		

Please complete all that apply:

- Filed for disability Approved (*List amount above*) Not approved Waiting
- Filed for Medicaid Approved Not approved (*Provide copy*) Waiting
- Unemployed, looking for work
- Other, please explain _____

Who is helping with your expenses? _____

Assets: In general, most companies do not ask specific information concerning assets held in order to qualify. If one or more of your medications is manufactured by any of these companies someone will contact you.

I agree to have Preferred Hospital Group, LLC and its affiliates provide services as outlined and attest that the information provided in this application is to the best of my knowledge true and correct. HIPAA compliance and other authorizations will be sent to the patient.

PATIENT SIGNATURE: _____ **Date:** _____

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Please print neatly

Payment Authorization

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Patient Name(s): _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Email: _____ **Other Phone:** _____

ENROLLMENT FEE: You **must** complete one of the payment options below and your Enrollment Fee must be received for your application to be processed. Will be processed immediately.

\$50.00

Check or money order. Make payable to Preferred Hospital Group, LLC.

Charge or draft account given below.

MONTHLY SERVICE FEE: You **must** complete one of the payment options below for your application to be processed. Will begin 30 days from receipt of application.

\$50.00 - unlimited PAP medications managed

Provide payer information **exactly** as it appears on statement.

Payer Name: _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Email: _____ **Other Phone:** _____

Credit or Debit Card:

I, _____, hereby authorize **Preferred Hospital Group, LLC** to charge my credit card for the Enrollment Fee and Monthly Membership Program Fees as described above.

Visa MasterCard Discover

Card Number: _____ Exp Date: ____/____

Bank Draft: Checking *Please Include Voided Check* Savings *Please Include Deposit Slip*
Pre-Authorization Payment Plan: Authorization to honor withdrawals by Preferred Hospital Group, LLC.

Name of Financial Institution: _____

Routing #: _____ Account #: _____

Monthly Membership Payment Date: 5th 15th 25th The 5th will be used if none is selected.

As a convenience to me, I, _____, request and authorize you to charge my account for payments drawn by and payable to **Preferred Hospital Group, LLC** as described above, provided there are sufficient funds in my account to pay the same upon presentation. I agree that my rights in respect to each payment shall be the same as if drawn by me and signed personally by me. This authority is to remain in effect until revoked by me in writing at least 14 days prior to next draft and until you receive notice, I agree you will be fully protected in honoring any such check or electronic debit.

Signature: _____ **Date:** ____/____/____

Cancellation/ Refund Policy: Monthly memberships may be cancelled at any time after enrollment with a minimum of **14 days** notice **in writing** prior to the next billing cycle. Refunds will be granted to members who fail to qualify for **all** PAP programs and submit denial letters from all pharmaceutical companies involved within **120 days** of enrollment, assuming all information has been provided completely and accurately.

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