MEDBANK

c/o Whitfield Co. Health Dept.
808 Professional Blvd.
Dalton, GA 30720
Phone: (706) 281-2363

Dear Patient:

MEDBANK is an organization that will help you get your medications free of charge, or at a reduced cost, directly from the pharmaceutical companies that manufacture the medications. Our purpose is two-fold: to provide access to free or substantially reduced cost, chronic-illness medications to patients who are without prescription insurance or personal funds sufficient to purchase such medications, and secondly, to relieve you of the paperwork associated with seeking such assistance from the various pharmaceutical companies' patient assistance programs (PAP).
There is a charge to each patient of $10.00 per month. This is NOT $10.00 per medication…..it is just <u>$10 per month</u> no matter how many medications we order for you, or how many medications you do or don't pick-up every month. A total of $120 per patient a **year** is the total cost. Your first monthly payment is due when you pick-up your first medication.

Please carefully read the attached information that you have received. You will need to make sure you have <u>everything</u> together before we can begin the application process. This means you will need to:

1) Have the *Physician Referral Form* completed by your doctor (your doctor and/or nurse will fill out this form at their <u>office</u>);
2) Realize that the income guidelines, which are set by the drug companies, are $16,000/yr or less for a Single household and $25,000/yr or less for a Married household;
3) Have <u>all</u> of the financial information together that **applies** to you and your household (see *Financial Information* form).
4) If you have ever received <u>any</u> type of help during this year in getting your medications, please indicate that on the "Patient Information" sheet.

Please understand that MEDBANK has no control over the availability of medications in the prescription assistance programs nor does MEDBANK have control over the qualification(s) that the drug companies may require to receive their medications free of charge. Once your application is sent to the drug company(s), it can take four (4) to eight (8) weeks before you become qualified AND to receive your medication(s). It is therefore **your** responsibility to make sure you have an adequate supply of your medicine(s) until that time. IF YOU HAVE ANY CHANGES IN DOSAGES OR CHANGES IN ACTUAL MEDICINES FROM YOUR DOCTOR, IT IS <u>YOUR</u> RESPONSIBILTY TO GET MEDBANK <u>DOCUMENTATION</u> OF THOSE CHANGES.

When you **mail** back all of the required information MEDBANK needs to process your application for the prescription assistance program, MEDBANK call you to set up an appointment to sign the application(s) when they are ready.

We look forward to being of service to you!

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Fax: (706) 876-1558

HOW MEDBANK WORKS

1. Your doctor refers you to us. **STOP HERE** if you have not talked with your Doctor about MEDBANK.
2. YOU will need to gather information that the drug companies will need (your proof of income, insurance information, etc.). We **CANNOT** apply for your medications until we have all of the required information. THIS INCLUDES THE REFERRAL FORM FROM YOUR DOCTOR.
3. For requested information in "Step 2", you need to **mail** all of the requested information that MEDBANK has asked requested. Please clearly mark your envelope with MEDBANK's name on it.
4. When MEDBANK has **all** of the required information, we will complete the application form(s).
5. MEDNBANK will then call **you** to set up an appointment to sign the application(s).
6. After you sign the application(s), we will send it to your doctor for his/her signature, and to attach a prescription(s) if needed.
7. Your doctor or his/her staff will then send the application(s) to the drug companies.
8. Drug companies can take up to eight (8) weeks to send your medication(s) back to MEDBANK's location. It is therefore **your** responsibility to make sure you have an adequate supply of your medicine(s) until that time. Also please remember that MEDBANK has no control over the availability of drugs ordered nor do we have control over the qualifications that each drug company imposes in order to receive their medications free.
9. The drug companies will ship medications directly to MEDBANK's location.
10. We will call you when you can come to MEDBANK's location on a specified date and time to have a registered pharmacist, who is volunteering his/her time to our program, to dispense your medication(s). You must give us a phone number that allows us to leave you a message when we call you about your medication(s). Your first $10.00 payment will be due when you pick-up your medication(s).
11. **Any medication that is not picked up within a one (1) week time period of said pick-up date will be disposed of by MEDBANK**.
12. Every year (we will notify you) you must provide us with updated income information so that we may continue applying for medications for you.

IF YOU HAVE ANY CHANGES IN DOSAGES OR CHANGES IN YOUR MEDICINES FROM YOUR DOCTOR, IT IS YOUR RESPONSIBILTY TO GET MEDBANK A NEW DOCTOR'S REFERRAL FORM (DO NOT BRING IN AN ACTUAL PRESCRIPTION) THAT SHOWS THOSE CHANGES.

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FINANCIAL INFORMATION

The pharmaceutical companies require MEDBANK to obtain financial information from patients for eligibility purposes. The general income guidelines to receive medications free are: $16,000 or less for Single household and $25,000 or less for Married household. If you do not meet these requirements, there is no need to continue.

So we can process your application as quickly as possible, we will need any and all of the following information that applies to you and your household.

Use this worksheet to help you decide what you need to send. **Anything you say "Yes" to, MEDBANK needs a copy of sent to our mailing address.**

______Will you file a **Federal** tax return in 2004? If YES, we will need a complete **copy** of the return as soon as it is available.

______ Are you or anyone in your household currently employed? If YES, we will need **copies** of the most recent paycheck stubs for the past two (2) months.

______ Do you or anyone in your household receive benefits from Social Security? If YES, we will need from everyone in your household receiving Social Security benefits: 1) a **copy** of your 2005 benefit statement which indicates what your current dollar amount is for each month (a copy of your Social Security check is acceptable), **AND** 2) a **copy** of Social Security form SSA-1099 for 2004-this should be mailed to you in January 2005. You can get these two (2) forms for you and everyone in your household from the local Social Security Office or call their toll-free number at 1-800-772-1213 and request copies.

______Do you or anyone in your household receive income from any other source, such as, but not limited to, a pension plan, interest income, unemployment benefits, insurance premiums, etc.? If YES, we will need a **copy** of the source's 2004 year-end statement and a copy of the source's monthly check.

______Do you (as the person applying for help) have medical/health insurance provided by Medicare, Medicaid, a Medicare supplemental policy, or from a private health insurance policy? If YES, we will need **copy(s)** of the insurance card(s) (front and back copy) which shows the name and address of the insurance company, the telephone number and policy number.

Failure to return any of the above information that applies to you and your household will delay the application process.

ALL INFORMATION YOU FURNISH TO US IS TREATED WITH THE UTMOST RESPECT AND CONFIDENTIALITY.

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PATIENT INFORMATION

Name:____ Male ___ Female ______
Last First MI

Street Address:____
City Zip

Mailing Address:____
City Zip

Please make sure you list a phone number where we can leave a message: Phone #_____________________

Is this phone # for: Home? Work? Cell? Other?_________________________

Date of Birth:_____________________ Social Security Number:____________________________

Marital Status (please circle): Single Divorced Married Widowed

Do you have a Medicare card? Yes___ No____ If Yes, Please make a copy of the card

Do you have GA Medicaid card? Yes___ No______ If Yes, Please make a copy (front & back) of the card

Have you ever applied for Medicaid and were denied? Yes______ No______ If YES, PLEASE ENCLOSE A COPY OF YOUR MEDICAID **DENIAL** LETTER WITH THIS FORM.

Are you a Veteran? Yes___ No____

Are you **legally** disabled? Yes___ No____ If Yes, how long have you been disabled?_____________

Do you have private medical insurance? Yes___ No___ Does it cover medications? Yes___ No___

Do you have Medicare supplemental medical insurance? Yes___ No_____If Yes, Please make a copy (front & back) of the card

Does it cover medications? Yes_______ No___

How many people live in your household? Adults______ Children_________

Have you ever received help in getting your medications free or at a discount? (not samples from your Doctor)
Yes___ No______

If YES, where were you getting help and when was the last time you got these medications?________________
____
____

Which Doctor (s) in Whitfield/Dalton are you a patient with?

1.____

2.____

3. ____

Please return this form

MEDBANK
Authorization to Share Health Information
For Prescription Assistance Program

I, ________________________________, allow my doctor(s), any other health care providers, advocate, and my health plan or insurers to give medical information relating to my use or need for MEDBANK in getting help with my prescriptions.

This information can include spoken or written facts about my health and payment benefits I may have. It can include copies of records from my health care providers or health plans about my health or health care.

MEDBANK will use and give out this information to see if I qualify for the Prescription Assistance Program and to run the Prescription Assistance Program. People who work for and with MEDBANK may also see my information, but they may use it only to help me get assistance with the cost of my prescriptions. I understand that they will make every effort to keep my information private. If it is accidentally given out, I understand that the federal Privacy Rule ("HIPPA") does not protect the privacy of information if disclosed, and therefore request that all information obtained from this person or agency be held strictly confidential and not be further released by the recipient. I further understand that my eligibility for benefits, service or payment is not conditioned upon my provision of this authorization. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and understand that my authorization will remain in effect for: (PLEASE CHECK ONE)

( ) ninety (90) days unless I specify an earlier expiration date here:______________________________

( ) one (1) year.

I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may withdraw this authorization at any time.

This Authorization will last until I am no longer participating in MEDBANK's Prescription Assistance Program. If I change my mind before that, I can tell my health care providers and my insurers in writing that I do not want them to share any more information with MEDBANK, but it will not change any actions they took before I told them. I know I have a right to see or copy the information my health care providers or insurers have given to MEDBANK.

I KNOW THAT I MAY REFUSE TO SIGN THIS FORM. My choice about whether to sign this form will not change the way my health care providers or insurers treat me. If I refuse to sign this form, I know that this means I may no longer be able to receive assistance from MEDBANK.

Date: ____________

Patient Signature:______________________________________

Patient Name:____

If the patient cannot sign, patient's personal representative must sign below:

Patient Name:____

By:____

(signature of person signing)

Describe the relationship to patient and authority to make medical decisions for patient:

____

Please return completed form

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PATIENT SIGNATURE AUTHORIZATION

I authorize representatives of MEDBANK to sign forms on my behalf for the sole purpose of soliciting medications on my behalf from companies that manufacture or provide medications through patient assistance programs. This signature authorization is good as long as MEDBANK is assisting me or until I revoke such.

FULL PRINITED NAME OF PATIENT:____

SIGNATURE:____

DATE:_________________________

Please return completed form