PATIENT ID:	DATE:

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE NAME:
TOTAL # IN HOUSEHOLD:	# OF ADULTS (SELF INCLUDED):	# OF CHILDREN:

STREET ADDRESS:	HOME PHONE ( )	CELL PHONE ( )

CITY:	STATE:	COUNTY:	ZIP:

Email:

ALLERGIES:

PLEASE CHECK IF YOU QUALIFY OR RECEIVE ANY OF THE FOLLOWING:

☐ MEDICAID ☐ MEDICARE PART D ☐ TRICARE ☐ COMMERCIAL INSURANCE

Total Household Income: $

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ WIDOW

SOCIAL SECURITY NUMBER:	BIRTHDATE:	SEX: ☐ M ☐ F

ETHNICITY:	DISABLED ☐ Yes ☐ No	VETERAN ☐ Yes ☐ No

IN CASE OF EMERGENCY, PLEASE CONTACT:

NAME:_____**PHONE:**_____**RELATIONSHIP:**_____

The above information is true to the best of my knowledge. I am aware that any fraudulent information or statements will automatically disqualify me from MedBank's services. I agree to provide all necessary documentation and patient cooperation.

_____ _____

SIGNATURE (Patient or Parent/Guardian) **PRINT (Patient or Parent/Guardian)**

For MedBank Staff

Application Processed By: _____ **Date:** _____

Last Name: **First Name:** **Middle Name:**

PHYSICIAN INFORMATION

Title: _____First Name: _____ Last Name: _____

Facility Name:_____

Address_____Suite: _____

City: _____ State: _____ Zip: _____

Office Phone: (_____) _____ Office Fax: (_____) _____

Office Contact: _____ Office Email: _____

MEDICATION	STRENGTH	DOSAGE

For MedBank Staff

Application Processed By: _____ Date: _____

Last Name: **First Name:** **Middle Name:**

In order to assist you quickly and efficiently, we ask that you take responsibility for the following:

- **Proof of Income:** In order to receive *most* medications, pharmaceutical manufacturers require patient to provide proof of income with the application. MedBank Case Specialists will work with you to ensure that you have the form required for your specific medications. This may include the following:
  - 1040 Tax Form
  - Schedule C Form (if self-employed)
  - Four (4) consecutive and current pay stubs
  - Proof of other income- family assistance, state assistance, Social Security Benefit letter, Social Security Disability Benefit, Pension, Alimony, Child Support, Unemployment, Etc.
  - Unemployment- Wage Verification Form from the Department of Labor
  - Physician Acknowledgement form

Initials	Responsibilities
	It is my responsibility as a patient of MedBank to keep medical provider information updated and current.
	I understand that in order for MedBank to process my refills I must inform MedBank staff once I have received my medication, either at my home or at my doctor's office. I understand that failure to do so may result in a delay in the arrival time of my next refill.
	I understand that once my application is processed by MedBank staff, it will then be sent to the manufacturers according to their guidelines. I also understand that the estimated time of arrival for my medications can vary from 2 to 6 weeks *after the application has received the necessary signatures from my doctor.*
	I understand that if I do not receive my medications within 6 weeks that it is my responsibility to notify the MedBank staff.
	I understand that it is my responsibility to provide MedBank with the necessary proof of income to receive my medication, and that failure to do so may prevent me from receiving my medication.

For MedBank Staff

Application Processed By: _____ **Date:** _____

MEDICAL RELEASE FORM

I authorize MedBank Foundation, Inc. and its affiliates to gather all medical records from my physicians, nurses, social workers, and any other personnel as needed. I understand that the information gathered will be used solely for the purposes of MedBank Foundation, Inc. and will not be released or shared with any outside institutions, companies, or other non- authorized personnel.

Further, I authorize MedBank Foundation, Inc. to release my medical information to pharmaceutical companies as deemed necessary for the purposes of processing applications and requests for prescription assistance.

This release shall only be valid from the date of signature to the end of my participation with MedBank Foundation, Inc. services or until I notify MedBank Foundation, Inc. in writing to discontinue services provided.

Patient Name (Please Print)**:**_____

Date of Birth: _____**SSN:** _____

Street Address: _____

City: _____**State:**_____**Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____

_____ _____
Patient's Signature **Date**

_____
Witness' Name (Please Print)

_____ _____
Witness' Signature **Date**

MEDBANK CLIENT RESPONSIBILITIES

As a MedBank client, you agree to follow MedBank's policy and operating procedure in order to enroll in and obtain prescription assistance. Failure to comply with Client Responsibilities as outlined below could potentially cause a delay in receiving your medications or result in termination from MedBank services.

MEDBANK CLIENT RESPONSIBILITIES

- Client agrees to provide Proof of Income, (POI), and other required documentation needed to complete the Patient Assistance Program application provided by the pharmaceutical manufacturer. Failure to provide POI as requested will delay program enrollment or program renewal and will prevent client from receiving medications timely.

- Client agrees to provide MedBank Case Specialist with information for current, prescribing medical provider. If Client changes medical providers, he/she agrees to contact MedBank Case Specialist to provide name and contact information of new, prescribing medical provider. Failure to provide timely updates could delay receipt of medications or result in dismissal from the Patient Assistance Program.

- If Client is approved for prescription benefit coverage through eligibility for Medicaid, Medicare, or private insurance, then Client agrees to notify MedBank Case Specialist immediately of prescription benefit coverage.

- Client agrees to notify MedBank Case Specialist, by phone or email, to confirm receipt of medications, after having picked up medications from medical provider's office or receiving medications by mail at Client's home address.

- Client agrees to notify MedBank Case Specialist if medications are not received within 5 weeks of submitting an application for assistance.