CONCORD HOSPITAL

Data Base Code: _____ MR#_____

Dear Patient:

Thank you for your recent inquiry regarding the Concord Hospital Prescription Assistance Program.

The goal of this program is to assist eligible uninsured and underinsured patients of all ages to receive needed prescription medications from pharmaceutical companies.

Prescription assistance is a program that helps patients receive free medications if they qualify based on each pharmaceutical companies financial guidelines. You can find out if you qualify by completing the following enrollment form and turning in all required documentation.

Please complete the enrollment form and attach copies of all required documentation that apply to you. We will also need copies of the front and back of all insurance and prescription cards.
Please return to: Concord Hospital Prescription Assistance Program 250 Pleasant Street Concord, NH 03301.

Please submit the following: (if applicable)

- Current **Social Security Benefit Statement (must show the monthly amount received).**
- Current **Social Security Yearly Benefit Statement – Form 1099.**
- Current **Pension Benefit Statement (must show the monthly amount received).**
- Current **Pension Yearly Benefit Statement - Form 1099.**
- Copy of any other **Income:** check stubs from salary/wages, unemployment statements, and child support and/or alimony letter. **(Must include most recent month).**
- A copy of your most recent **signed** income **Tax Return.**
- Copy of **Insurance and Prescription cards, front and back.**

Once we receive your enrollment form and all required documentation we will begin processing your applications to the pharmaceutical companies. This process can take anywhere from 4-8 weeks depending on the pharmaceutical companies turnaround time.

Please keep the following in mind that this is an "assistance" program. We are assisting you with applying for your medications through the pharmaceutical companies. **The companies make the ultimate decision about your approval in the program.**

You will need to continue to purchase your medications through a pharmacy until your medications have been approved.

Thank you for your interest in the Concord Hospital Prescription Assistance Program. If you have any questions, please contact us between the hours of 8AM-4PM Monday through Thursday at (603)227-7009.

Sincerely

Kim Merrill- Silva & Frances Bliss
Concord Hospital Prescription Assistance Program
Phone: (603) 227-7009
Fax: (603) 227-7010

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Concord Hospital
Prescription Assistance Enrollment Form

Name: _____Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone #: _____ Social Security #: _____ - _____ - _____

Number of Household Members: _____

Income:	**Source:**	**Total Household Income:**
$_____	_____	
$_____	_____	
$_____	_____	$_____

Please provide current proof of income. If no income, please provide letter of explanation.

Please Circle: ☐ Female ☐ Male ☐ Widowed ☐ Divorced ☐ Married ☐ Single

Prescription Insurance: ☐ Yes ☐ No *(If yes, enclose a copy of insurance card, front and back)*

Do you file income tax returns? ☐ Yes ☐ No *(If yes, enclose a copy of your signed taxes)*

Medicare: (circle all that apply) ☐ A ☐ B ☐ D *(If D is checked, enclose copy of insurance card, front and back)* ☐ None

Medicaid: ☐ Yes ☐ No Spend Down Amount: **(if applicable)** $_____

List Medication Allergies:

List *LONG TERM* Prescription Medications you are currently taking:

Please continue to the back side to complete & sign.

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PLEASE LIST YOUR PCP ALONG WITH ANY PHYSICIAN'S THAT PRESCRIBE YOU LONG TERM MEDICATIONS.

Primary Care Physician (PCP)

Name: _____ Phone#: _____

Address: _____

_____

Office Use Only:

*DEA#:*_____*Lincense#:*_____*NPI#:*_____

Physician #2

Name: _____ Phone#: _____

Address: _____

_____

Office Use Only:

*DEA#:*_____*Lincense#:*_____*NPI#:*_____

Physician #3

Name: _____ Phone#: _____

Address: _____

_____

Office Use Only:

*DEA#:*_____*Lincense#:*_____*NPI#:*_____

PLEASE COMPLETE BELOW ALL MEDICATIONS YOU ARE SEEKING ASSISTANCE WITH .

MEDICATION	STRENGTH	DIRECTIONS/SIG.	PRESCRIBER

Signature: _____Date: _____

Office Use Only:

*GSK#:*_____*Pfizer#:*_____ *#:*_____