Member Registration

Agent/Agency:	Agent ID:	Company:

Internal Use Only

PATIENT INFORMATION

Last Name:		First Name:	MI:
Address:		SS#:	Birthdate:
Address 2:		Gender (circle one): ◯ Male	◯ Female
City:		Size of Household:	
State:	Zip:	Annual Household Income:	
Email:		Insurance Carrier:	
Phone:		Medicare D (circle one): ◯ Yes	◯ No
Prescriptions (name, dose, frequency, price):		Prescribing Physician (name, address, phone, fax):	

By completing and submitting this form, you agree to allow an Rx Help Centers advocate to contact you regarding your prescriptions. The information that you provide will be used to determine program eligibility and will NOT be distributed to third parties. Once Rx Help Centers begins to advocate on your behalf, you can expect your brand and specialty medications to be approved in as little as 3 weeks. Generics that we assist will be approved in as little as 3 days. This processing time will vary depending on your cooperation and that of the prescribing physician.

Please initial if you understand and agree with the statement above. *

I Agree _____

Patient Signature _____ Date _____

Please submit this form via **Fax: (866) 938-6151** **Email:** billing@rxhelpcenters.com