

**PATIENT INFORMATION**

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: (     ) \_\_\_\_\_  
 Mobile Phone: (     ) \_\_\_\_\_ E-Mail Address: \_\_\_\_\_  
 Marital Status: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ S.S.# \_\_\_\_\_  
 The best time to contact me:  MORNING  AFTERNOON  
 What is your annual income from all sources? \_\_\_\_\_

**ALTERNATE CONTACT INFORMATION**  
 (person assisting patient with their medications, if applicable)

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
 Home Phone: (     ) \_\_\_\_\_ Work Phone: (     ) \_\_\_\_\_

**PHYSICIAN INFORMATION**

(Only list those doctors who prescribe medications listed below)

**DOCTOR #1**

**DOCTOR #2**

Name: \_\_\_\_\_  
 Facility Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Suite: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Office Phone: (     ) \_\_\_\_\_

Name: \_\_\_\_\_  
 Facility Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Suite: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Office Phone: (     ) \_\_\_\_\_

**PRESCRIPTION INFORMATION**

(Please put the prescribing doctor # with each medication)

Dr#	Brand/Generic	Strength	Frequency

**AUTHORIZATION AGREEMENT FOR DIRECT PAYMENT**

I want to pay my monthly service fee by:

- BANK DRAFT (IMPORTANT: You must attach a copy of your voided check)  
 CREDIT CARD    \_\_\_ Visa    \_\_\_ MasterCard

Card #: \_\_\_\_\_  
 Exp. Date: \_\_\_\_\_ 3-Digit Security Code: \_\_\_\_\_

DEDUCTION AUTHORIZATION: I authorize EZMeds USA, or its designated attorney-in-fact, to electronically draft my account above or charge my credit card for my application fee and monthly membership. This authorization will remain in full force until EZMeds USA receives written notification from me of termination of service. Please allow 30 days to process cancellation.

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MAKE CHECK PAYABLE TO EZMeds USA**

# of Prescriptions	Monthly Fee	1x Enrollment Fee	TOTAL
1 **	\$39.95	\$25.00	\$64.95
2—4	\$69.95	\$25.00	\$94.95
5—8	\$119.95	\$25.00	\$144.95
9—12	\$169.95	\$25.00	\$194.95

Provider: \_\_\_\_\_

## EZ Meds USA (EZ Meds) General Information

You understand: that not all medications you are taking may be available through the pharmaceutical companies free drug programs and each company has income and pharmacy coverage guidelines.

Your gross yearly family income needs to be less than illustrated on the income chart and each pharmaceutical company may have different guidelines. Also, you currently have no coverage (insurance or government program) that reimburses or pays for your prescription medications and you are experiencing a hardship in purchasing them.

You will be required to provide proof of my income before any services will occur on your behalf.

One your applications have been completed by EZ Meds, they will be mailed to your doctor for his/her signature. Your doctor will then mail them back to EZ Meds so they may be forwarded to the appropriate pharmaceutical company(s). EZ Meds cannot be held responsible if applications are not returned by the doctor.

Once the completed applications for the pharmaceutical companies PAPs (free drug programs) are returned to EZ Meds it may take 6-8 weeks before you would receive the first shipment of medications (generally a 90 day supply). The pharmaceutical company determines whether my medication is shipped to the physician, picked up at a local pharmacy, or shipped directly to your home. Clients or EZ Meds cannot decide where medications are to be delivered.

You are authorizing the alternate contact, if filled-in, on the Enrollment Form be approved to act on my behalf with regards to my account/records with EZ Meds. You can cancel your service at any time, but no refund will be issued.

With regard to the pharmaceutical companies PAPs, EZ Meds acts only as a processing assistant to help you apply for and complete applications necessary to receive free drugs offered by pharmaceutical companies we do not manufacture drugs, prescribe drugs, dispense drugs, recommend medication, or evaluate prescriptions.

You attest that the information provided in this application is complete and accurate. By your signature, I authorize EZ Meds USA, LLC. to request and obtain from my healthcare provider, insurance company, or pharmaceutical company/manufacturer or its contractors any of my medical records and information, financial and insurance records and information, and/or any other information necessary for the purpose of verifying the accuracy of the information provided in this application or related to my enrollment or participation in the various pharmaceutical patient assistance programs (PAPs). I understand that any such information obtained, as well as the information provided to me in this application, will be used by EZ Meds USA, LLC. and its authorized agent(s) solely to administer the PAPs and those services provided only by EZ Meds USA, LLC., but will not be used or disclosed for any other purposes, except as may be required by applicable law. I understand that neither EZ Meds USA, LLC. Nor my healthcare provider may be held responsible in the event I provide information deemed to be fraudulent. Please include proof of income, latest tax return (first page only) or Social Security income statement.

### Temporary Power of Attorney

1. I \_\_\_\_\_ give "EZ Meds USA" and is representative(s) permission to apply for medication assistance programs on my behalf. "EZ MedsUSA" will have limited Power of Attorney to sign any necessary paperwork, applications and/or documentations concerning the assistance programs.
2. I understand that I may revoke my authorization at any time by providing a written request of termination of services with "EZ Meds USA", Processing Center, P.O. Box 43064, Las Vegas, Nv 89116.
3. A copy of this authorization may be accepted as an original.

\_\_\_\_\_  
Member's Name (Print) (\_\_\_\_\_-)(\_\_\_\_\_-)(\_\_\_\_\_-)  
Member's Social Security Number

\_\_\_\_\_  
Member's Signature Date

\_\_\_\_\_  
Name of Personal Representative (If applicable) Relationship to Member

PLAN ADMINISTRATOR:



P.O. Box 15640 • Scottsdale, Arizona 85267

Local (480) 502-3773 • Fax (480) 502-3993

Toll Free: 888-396-3371