

Welcome to Rx Help Centers

Congratulations! We are thrilled that you have chosen Rx Help Centers as your personal prescription advocate!

Rx Help Centers is proud to work on your behalf to save you money on prescription medicine. We believe that you should be able to receive the medicine you need without creating financial duress. Our programs are designed to give you the most assistance on all of your meds so you can concentrate on living life instead of worrying about money.

HIPAA

In order for us to help you, we will need to have a HIPAA form on file that will allow us to speak with your doctors and prescription manufacturers/grantors. I've attached our HIPAA form to this letter so that you may complete your section and return it to us.

Please, when you're filling out this form, only complete the very top portion, inside the red box, containing PATIENT information and sign the form. The other sections are for Rx Help Centers to complete. We will insert your physician's information and the information of the third party involved (manufacturer/grantor) for each medication that we are helping you with.

If you have any questions, please email us at help@rxhelpcenters.com or call us at 866-478-9593.

If you are a part of the Facebook online community, be sure to become a fan of Rx Help Centers' page www.facebook.com/RxHelpCenters!

Jeff Christensen

CEO – Rx Help Centers



AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Note: Fees may apply to certain requests

Patient Name:	
SSN:	Date of Birth:
Address:	
City:	
State:	Zip Code:
Phone:	
Email:	

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RX He	elp Centers will not condition treat on providing or refusing to	tment, payment, or eligibility for be provide this authorization.	penefits		
	e following medical facility or	RX Help Centers may disclose this information to Check if same as above (disclosure to patient) Recipient Name:			
to disclose informatio	n as specified below for the RX Help Centers will be	SSN: Date	e of Birth:		
	otion advocate for the	Address:			
	provide assistance with	City:			
prescribed medicat	tions.	State:Zip	Code:		
		Phone:			
		Email:			
☐ Both Hospital and Me☐ Records limited to a☐ X-Ray films ☐ NOTE: Hospital and	or medical record information we dical Office Records	I Office Records ☐ Presc or department: tory Results clude disclosure of information	ription Records		
antibody tests are Mental Health depar	ndency treatment records -> S	I not be disclosed unless you si Signature:	ign below.		
Media Type: 🗆 Elec	tronic Paper Delivery Pre	ference: Email/Secure Portal	☐ Mail ☐ Pickup		
DURATION:	This authorization shall remain in different date is specified here:	effect for one year from the date (date).	of signature unless a		
REVOCATION:	•	voke this authorization upon writte on disclosed before the receipt of t			
REDISCLOSURE:	longer be protected under federa	sclosed, how the recipient further of privacy law (HIPAA). California refurther disclosing this information.	3		
the same or similar in	a form to be completed, we may soformation requested. zation is as valid as an original. I have		·		
Date	Signature	If not patient, print your na	me and relationship		

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

Form # RXHCDPHI-01



Employee ID:

Employee Registration

Agent/Agency:		Agent ID:		Compar	ny:	
Internal Use Only						
PATIENT INFORMATION			Γ			
Last Name:			First Name:		T	MI:
Address:			SS#:		Birthdate	9:
Address 2:			Gender (circle one)	:	Male	Female
City:			Size of Household:			
State:	Zip:		Annual Household	Income:		
Email:			Insurance Carrier:			
Phone:			Medicare D (circle o	one):	Yes	No
Prescriptions (name, dose, frequen	ncy, price):		Prescribing Physicia	ın (name,	address,	phone, fax):
By completing and submitting this form, The information that you provide will be						
Centers begins to advocate on your beha	alf, you can e	xpect your brand	I and specialty medicati	ons to be a	approved in	as little as 3 weeks.
Generics that we assist will be approved he prescribing physician.	in as iittie as	3 days. This pro	cessing time will vary d	epenaing c	on your coo	peration and that of
Please initial if you understand and agree	e with the sta	itement above. *				
Agree						
<u></u>						
Patient Signature			D	ate		
Please submit this form via		av. (866) 03	8-6151 F	mail· hilli	ina@rvholi	ncantars com

Form # RXHCREG-01 Rev 02/2015



Representation Agreement Prescription Drug Advocacy

In order to successfully assist our clients, Rx Help Centers requires certain permissions to act on their behalf. For that reason this document must be signed granting specific permissions which are detailed herein.

The client provides Rx Help Centers advocates the power to act on their behalf for the sole purpose of **prescription drug advocacy**. This is effective as of the date signed and will remain until the time the client no longer requires assistance from Rx Help Centers for the purpose of prescription drug advocacy. Withdrawal of these permissions will terminate the clients future prescription drug advocacy services.

Rx Help Centers will have the following powers:

- Contact physicians on my behalf Rx Help Centers may contact my physician(s), discuss
 prescription information, and request documentation for the purpose of obtaining assistance
 on the client's prescription drugs.
- Contact third parties on my behalf Rx Help Centers may provide information I have provided which is required information requested by a third party. This includes my financial information and any information required by the third party in order to complete the advocacy process.
- Electronically sign on my behalf Rx Help Centers is authorized to digitally sign documentation on my behalf for the sole purpose of prescription drug advocacy.

By signing this document, I acknowledge all of the above conditions and information contained on this document. Any inquiries can be directed to the number listed on this document by email to billing@rxhelpcenters.com

Print Name:			
Signature		Date:	