



## ENROLLMENT FORM

Nobody should have to choose between buying groceries and paying for their medications. We can help.

**EZMeds** USA  
[www.yourezmeds.com](http://www.yourezmeds.com)

Thank you for your enrollment in EZMeds USA's pharmaceutical company "PAP" patient advocate service. We look forward to assisting you with your prescription assistance needs. **At this time, we want to make certain you understand how our service works.**

First of all, it is important to understand that you are hiring EZMeds USA as your patient advocate. We will handle all the required paperwork involved with your initial application process, any dosage changes, all refill requirements, re-applications and/or re-enrollment procedures, etc as determined by each program's sponsor. And, understanding the varying pharmaceutical company renewal procedures and timelines, it's also important for you to know that we are initiating required services for your next shipment of medication long before your current supply has been exhausted.

Patient advocacy is an ongoing procedure and, as your advocate, EZMeds will do everything necessary to ensure that you continue to receive your medication on-time, uninterrupted. **Also, please understand, you pay a monthly service fee for this advocacy, with no limit to the number of drugs you are taking.**

Because of this, do not confuse the amount of medication you receive or have on hand with the monthly service fee amount. Finally, since all of your work is done in advance your medications are shipped in 90-day supplies,

By having already submitted your Enrollment Form you've already paid your one-time, non-refundable enrollment fee and your first months service fee (\$122.00). So, on approximately the first of each following month we will debit your checking, or credit card account the monthly service (\$97.00) fee to keep your account current. (Your first debit may vary according to your enrollment date.) Please understand if you are past 30 days in paying your monthly service fees you will risk interrupting your scheduled medication shipments.

**Thank you for allowing EZMEDS USA to be your patient advocate.**

**Start saving money today!  
Call us toll free:**

**888-396-9211**



## Affordable, name-brand medications are just 3 steps away!

### STEP 1:

#### EZ MEDS ANNUAL INCOME QUALIFICATIONS

Use this list to determine the income eligibility of you and/or your family.

PERSONS IN FAMILY OR HOUSEHOLD	INCOME (48 CONTIGUOUS STATES AND D.C.)
1 (Single)	\$20,420
2	\$27,380
3	\$34,340
4	\$41,300
5	\$48,260
6	\$55,220
7	\$62,180
8	\$69,140



### STEP 2:

#### Rx COVERAGE STATUS

- No Rx coverage from insurance benefit or government assistance program (e.g.: Medicaid, V.A., state assistance, etc.)
- Rx benefit has been exhausted
- Medication is specifically not covered under Rx formulary

### STEP 3:

#### MONTHLY FEES

ONE-TIME Enrollment Fee	\$25.00
Medication Monthly Fee	\$97.00

\$25 Enrollment Fee and first months service fee due upon enrollment (\$122.00)

## Name-Brand Medications, Substantial Savings

### EXAMPLES OF SAVINGS EXPERIENCED BY EZMEDS USA CLIENTS

#### CLIENT EXAMPLE #1

MED.	DSG/QTY	ONLINE RETAIL	EZMEDS USA \$
Advair®	250/50mcg/1 disc	\$190	\$97
Lipitor®	10mg/30 tablets	\$85	\$0
Plavix®	75mg/30 tablets	\$135	\$0
Nexium®	40mg/30 tablets	\$151	\$0
Singulair®	10mg/30 tablets	\$106	\$0
Zoloft®	25mg/30 tablets	\$89	\$0
<b>TOTAL COST PER MONTH</b>		<b>\$756</b>	<b>\$97</b>

**CLIENT #1 REDUCED THEIR TOTAL MONTHLY COST BY OVER 87%, SAVING THEM \$659 PER MONTH. WITH EZMEDS USA, THEY WILL SAVE OVER \$7908 PER YEAR!**

#### CLIENT EXAMPLE #2

MED.	DSG/QTY	ONLINE RETAIL	EZMEDS USA \$
Actos®	30mg/30 tablets	\$186	\$97
Celebrex®	200mg/30 tablets	\$190	\$0
<b>TOTAL COST PER MONTH</b>		<b>\$376</b>	<b>\$97</b>

**CLIENT #2 REDUCED THEIR TOTAL MONTHLY COST BY OVER 74%, SAVING THEM \$279 PER MONTH. WITH EZMEDS USA, THIS CLIENT WILL SAVE OVER \$3,348 PER YEAR!**

**Start saving money today!  
Use this convenient form to enroll now.**

# Enrollment Form

## PATIENT INFORMATION

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ S.S.# \_\_\_\_\_  
The best time to contact me during the work-week is in the: (circle one) Morning Afternoon

## ALTERNATE CONTACT INFORMATION (Calls, Paperwork, & Invoices may be directed here)

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

## PHYSICIAN INFORMATION

(Only list those doctors who prescribe medications listed below)

### DOCTOR #1

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

### DOCTOR #2

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

**The example below illustrates all of the costs involved in participating in this money-saving prescription drug program**

**ONE-TIME Enrollment Fee.....\$25.00**  
**Medication Monthly Fee..... \$97.00**

\$25 Enrollment Fee and first months service fee included due upon enrollment (\$122.00)

**Mail required payment and forms to:**  
**EZMEDS USA • P.O. Box 15640 • Scottsdale, AZ 85267 • 888-396-9211**

Dear EZMeds USA,

I have completely filled out and am submitting the Membership Enrollment Form along with this contract. Please process it and coordinate all available medications prescribed by my doctor with all applicable services available to me.

**I understand:**

- that not all medications I am taking may be available through the pharmaceutical companies free drug programs.
- that pharmaceutical companies have certain criteria that must be met and that the pharmaceutical companies will make the final decision as to who qualifies for their programs.

**Below are GENERAL GUIDELINES established for the pharmaceutical companies Patient Aid Programs:**

**Your gross yearly family income needs to be less than illustrated on the income chart. Total Gross Taxable Income includes: wages, social security, pension, disability, interest earnings, etc. (Excessive liquid assets may disqualify you from being approved for one or more medications).**

**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.**

- that I will receive a telephone (qualification) call from EZMeds to initiate qualifying me for the pharmaceutical companies' programs, and that when qualified, I will be required to provide proof of my income before any services will occur on my behalf.
- that the enclosed non-refundable \$25 enrollment and the first months fee is included with application.
- that once applications have been completed by, they will be mailed to my doctor for his/her signature. My doctor will then mail them back to EZMeds so they may be forwarded to the appropriate pharmaceutical company(s). EZMeds cannot be held responsible if applications are not returned by the doctor.
- that once the completed applications for the pharmaceutical companies PAPs (free drug programs) are returned to EZMeds it may take 6-8 weeks before I receive my first shipment of medications (generally a 90 day supply).
- that the pharmaceutical company determines whether my medication is shipped to my physician, picked up at a local pharmacy, or shipped directly to my home. Clients or EZMeds cannot decide where medications are to be delivered.
- that I am 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 EZMeds USA.
- I may cancel my service at any time, but no refund will be issued.
- that, with regard to the pharmaceutical companies PAPs, the facilitator acts only as a processing assistant to help me apply for and complete applications necessary to receive free drugs offered by pharmaceutical companies; they do not manufacture drugs, prescribe drugs, dispense drugs, recommend medication, or evaluate prescriptions.

*I attest that the information provided in this application is complete and accurate. By my signature, I authorize EZMeds 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 EZMeds USA, LLC. and its authorized agent(s) solely to administer the PAPs and those services provided only by EZMeds 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 EZMeds USA, LLC. nor my healthcare provider may be held responsible in the event I provide information deemed to be fraudulent.*

Name X Signature X Date X



14362 North Frank Lloyd Wright Blvd #1000  
Scottsdale, Arizona 85260 • Local (480) 502-3773  
Fax (480) 502-3993 • 888-396-9211

Provider:

# Automatic Monthly Payment Program

Monthly service fees are paid by bank draft or credit card.

## BILLING INFORMATION

### AUTHORIZATION AGREEMENT FOR PREAUTHORIZED PAYMENTS

Full name of individual paying for services (if not a member) \_\_\_\_\_

VISA     MASTER CARD     AMERICAN EXPRESS     MONTHLY BANK DRAFT (**Attach voided check**)

Card Number	Exp. Date	3-Digit Security Code	1st payment submitted with application
_____	_____	_____	_____

### AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH Debits)

Bank Name: \_\_\_\_\_ Branch: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Routing Number: \_\_\_\_\_

Account Number: \_\_\_\_\_

**This authorization is to remain in full force and effect until the COMPANY has received written notification from me of its termination in such time and in such manner so that the COMPANY will receive it 15 business days prior to the next scheduled transaction.**

Name on Credit Card \_\_\_\_\_ Billing Address \_\_\_\_\_

Signature **X** \_\_\_\_\_ Date: **X** \_\_\_\_\_

I request and authorize \_\_\_\_\_ (My Banking Institution) to accept and honor the same and to charge the same to my account. This Authorization will remain in effect until I notify the Originator and My Banking Institution in writing to terminate this Authorization, and Originator and My Banking Institution have a reasonable time to act on the termination of this authorization (not more than 30 days). *I also acknowledge receipt of a copy of this authorization on this date.*

In the event that my account has insufficient funds and the Originator incurs a fee as a result, I authorize the Originator to resubmit the draft at the original amount plus the fee resulting from insufficient funds charge-fee not to exceed \$10. I acknowledge that if a monthly draft payment is refused for insufficient funds or my account has been closed, Originator may, at its sole option, terminate this authorization agreement, at which times, my prescription services agreement may also be terminated.

**You must attach a copy of your VOIDED check here:**

# Authorization for Representation <-----

EZMeds USA, LLC is a patient advocate company that participates in various pharmaceutical companies sponsored "Patient Assisted Programs" (PAPs). These programs provide free prescription medications to qualified individuals. Each company sets their own qualification criteria, but all are intended for legal U.S. residents without prescription drug coverage who are experiencing a hardship purchasing them.

All programs, at various levels and times, require personal, financial and medical information as part of the application/qualification process. EZMeds USA LLC, requests your signature, as indicated below, to access and provide the programs this required information. And to sign any/all application forms as your authorized patient advocate representative pertaining to any and all matters regarding the pharmaceutical companies' Patient Aid Programs.

**By signing this form, I authorize EZMeds USA, LLC or its affiliates to act as my authorized patient advocate representative and hereby give them authority to sign any/all forms and applications on my behalf with regard to the pharmaceutical companies' Patient Aid Programs.**

Also, by signing this form, I authorize EZMeds USA, LLC or its affiliates to access and release any/all personal, medical and financial information requested that relates to the pharmaceutical companies' application/renewal process with regard to their respective Patient Aid Programs.

And, finally, by signing this form, I authorize EZMeds USA, LLC or its affiliates to sign any/all HIPAA (Health Insurance Portability and Accountability Act of 1996) forms on my behalf.

**X** \_\_\_\_\_  
EZMeds Client or Legal Representative Signature

**X** \_\_\_\_\_  
Date:

**X** \_\_\_\_\_  
Printed Name of PAS Client

# Enrollment Checklist <-----

**Please ensure that the following items have been completed before mailing your EZMeds USA Enrollment Form:**

- Authorization for Representation (signature needed and dated)**
- Enrollment Form/Back page (signature needed and dated)**
- Automatic Monthly Payment (signature needed and dated)**
- Payment with application - submit the first month of medication, with a one time application fee of \$25.00 for a total \$122.00. If made by check, make check payable to EZ Meds USA.**
- Pick from monthly bank draft or credit card. If you are using monthly bank draft, please include a void check with your first application.**
- Proof of income**

**MAIL REQUIRED PAYMENT AND FORMS TO:  
EZMEDS USA • P.O. Box 15640 • Scottsdale, AZ 85267 • 888-396-9211**