



Medication Assistance Program
 2700 Middleburg Drive, Suite 104
 Columbia, SC 29204
 800.763.0059
 Fax 877.731.2557

PATIENT INFORMATION

Last Name: _____ First: _____ MI: _____ Social Security Number: _____ Race: _____ Birth Date: _____
Month Day Year

Physical Address (no P.O. Box): _____ Phone: _____ Gender: Male Female Are you a legal resident? Yes No

City: _____ State: _____ Zip: _____ How did you hear about Welvista? _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Name of doctor's office or clinic: _____ Name of doctor or nurse practitioner: _____ Doctor's phone () _____

Medication allergies? Yes No If yes, list all allergies: _____

Do you smoke? Yes No Number of packs per day? _____

Check all medical conditions:

<input type="checkbox"/> Acid Reflux/GERD	<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> Hypo Thyroid
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Depression	<input type="checkbox"/> Hyper Thyroid
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes (sugar)	<input type="checkbox"/> Other _____
<input type="checkbox"/> Coronary Artery Disease/Heart Failure	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Seasonal Allergies
	<input type="checkbox"/> Hypertension (high blood pressure)	<input type="checkbox"/> Seizures

PATIENT ELIGIBILITY INFORMATION
ATTACH ANNUAL GROSS HOUSEHOLD INCOME (REQUIRED)

ANNUAL GROSS HOUSEHOLD INCOME (include all income, wages (2 consecutive weeks on pay stubs), social security, pension, disability, retirement, child support, annuity, alimony statement, rental income, workers' comp, unemployment, etc.)

Number of people in household: _____ \$ _____ **ANNUAL GROSS INCOME**

Do you have: (please check) Health Insurance Medicare Medicaid Family Planning VA Health No Health Benefits

STATEMENT OF RELEASE

I attest that the above information is complete and accurate. By my signature, I authorize the release of the information about me and my medical condition to Welvista and/or their agents. I authorize Welvista and/or their agents to use and disclose such information for the assessment of my eligibility for and enrollment into the Welvista program, which may include contacting and providing information to social workers, state agencies, healthcare providers or other persons or entities Welvista may deem appropriate to release medical records or required information bearing on my eligibility and benefits under the program. Additionally, I agree that at any time during my enrollment Welvista may request additional documentation to authenticate the statements made on my application. I will notify Welvista if I become eligible for Medicare, Medicaid, Health Insurance, VA Benefits, or if there is a change in my financial status.

I have received Welvista's Notice of Privacy Practices Statement

I authorize Welvista to ship my medications to: Name of Patient Agent _____
 (name of person)

Patient/Guardian signature _____ *Date* _____

Welvista Use Only

Date Received: _____
 Origination: _____
 Approved/Denied: _____
 Batch #: _____
 Paid: _____



Dear Applicant,

Thank you for your interest in the Welvista Medication Assistance Program. Attached you will find the application form for you to complete.

Welvista provides access to medications for qualified patients. Qualifications are determined according to guidelines established by Welvista and in accordance with our 12 pharmaceutical partners as well as state and federal guidelines.

To participate in our program, it is important that you complete all requested information and sign where indicated. Incomplete or incorrect applications will delay the application process so please ensure all information provided is correct.

PATIENT REQUIREMENTS:

- Complete and sign the Welvista application.
- Attach a photocopy of the **ANNUAL** gross household income. (i.e. Federal tax form (1040), social security income (SSA 1099), pensions, annuity, rental income, retirement, alimony statement, child support statement, statement of income from employer, unemployment, workers' comp, s.s. disability, with entitlement letter)
- Proof of residency (no p.o. box)
- \$20 processing fee

SUBMIT COMPLETED APPLICATION BY SELECTING ONE OF THE FOLLOWING OPTIONS:

- **MAIL:** Welvista, 2700 Middleburg Drive, Suite 104, Columbia, SC 29204
- **FAX:** 1-877-731-2557 (can only accept faxes from free clinics or hospitals that are invoiced)

Enrollment in program is for up to one (1) year and you are eligible for all medications on our formulary. A new application for renewal will be sent automatically to the patient prior to the renewal date.

Once application is received, it will be reviewed and your eligibility for participation in the Welvista Medication Assistance Program will be evaluated. You will be notified by mail upon completion of our review and evaluation. Please note that program rules are subject to change without notice.

If you are approved for the program, prescriptions are filled for a 90 day supply unless you are ordering a medication that is limited to a 30 day supply. Medication(s) will be shipped as designated on the application. Your doctor may write for refills for your medication(s). If so, you may request a refill 10 days before your prescription(s) run out by calling 1-800-983-3339 and following the recorded instructions on our IVR line. Please note that Welvista cannot contact your doctor for additional refills.

If you have any questions or need further assistance, please call 1-800-763-0059, between 8:30 a.m. and 5:00 p.m. Eastern Time, Monday through Friday. Please visit our website at www.welvista.org.

Sincerely,
Welvista