Complete this initial form & mail along with the required items listed below to:

Free Medicine Enrollment Form

make more copies if needed

P.O. Box 125
Doniphan, Mo. 63935-0125

Be sure to apply for all of your medications. There is no limit.

USA Bureau of Prescription Help

Helping Americans of **all ages** stay healthy

Be sure to include the following items: Toll-Free 1-888-812-5152 • www.FreeMedicine.com

1. The name, address and phone number of the person taking the medication(s) and list all of your medication(s).
2. The name and address of the doctor who prescribes the medication(s).
3. Send a refundable $10.00 (one-time processing fee) for **EACH** medication requested to Free Medicine Foundation. It is payable by cash, money order or check to "Free Medicine Foundation" and mail with this completed form.

(The medicine is free or low cost. The processing fee helps to fund and continue this program)

Please Print Clearly

First Name | M.I. | Last Name

Address (Street number / street name / apartment number / P.O. Box number)

City | State | Postal Code | Today's Date

Phone number | Date of Birth | M F Gender | $ _____ Total monthly household gross income

Email Address _____@_____

Are You Diabetic? ☐ Yes ☐ No

Are you on Medicare? ☐ Yes ☐ No

How did you hear about us? _____

	NAME OF MEDICATION	DOSAGE	Times Per Day	DOCTOR'S NAME & ADDRESS
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

More than 10 prescriptions? Attach an additional sheet of paper

0808

En español www.FreeMedicine.com

Money Back Guarantee Policy: If you are determined ineligible by all applicable sponsors, and receive no medicine assistance, send a written request to Free Medicine Foundation. Include denial letters for all applicable medications within 4 months of original application and your processing fee will be fully refunded.

Total number of medications requested ☐ **x $10 EACH = Amount due $**_____

Your application cannot be processed without the correct fee enclosed.

Please apply if you*: Are Uninsured • Under-Insured • Participate in Medicare Part D • Take medicine not covered by insurance • Have high deductible co-pays • Have insurance but low income • Generally, if you earn less in a year than the levels shown below, you may qualify to get all or some of your prescriptions free • $39,200 for single people • $52,800 for couples • $80,000 for a family of four • Special circumstances may apply if you earn more

*Other requirements may apply, each drug has its own eligibility criteria

One PAP application can provide you with free medicine for an entire year.
Re-apply as often as needed to receive a lifetime supply of free medicine.