



Xubex®
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<http://www.xubex.com>

Co-Pay Assistance Program Application Form

Use this application form to apply for Xubex's co-pay assistance program. Print and mail in the printed form along with your prescriptions to the address on this form. Offer can end or change without notice. Visit <http://www.xubex.com> for price and availability.

Patient Information					
First Name	<input type="text"/>	Mi	<input type="text"/>	Last Name	<input type="text"/>
Address	<input type="text"/>			Apt.	<input type="text"/>
City	<input type="text"/>	State	<input type="text"/>	Zip	<input type="text"/>
DOB	<input type="text"/>	Gender	<input type="text"/>	SSNumber	<input type="text"/>
Phone	<input type="text"/>			Alt. Phone	<input type="text"/>
Email Address	<input type="text"/>				

Drug Allergies

Codeine (32)
 Sulfa (87)
 Penicillin (70)
 Tetracycline (93)
 Other(00)
 Unknown (00)

Additional Allergies

Insurance Information

Name	<input type="text"/>	Bin#	<input type="text"/>	PCN#	<input type="text"/>
ID#	<input type="text"/>	Group#	<input type="text"/>	Phone	<input type="text"/>

Payment Information

Check
 Credit Card
 Card
 Cardholder Name

Card Number
 Exp. Date
 CVV

Prescription Transfer Information

Pharmacy Name
 Pharmacy Phone

Medication	Rx Number	Medication	Rx Number	Medication	Rx Number

By my signature I authorize Xubex to administer the following:

- 1) Use any information that I provide in my application to enroll in the program.
- 2) Receive and keep records of all prescriptions for the medications I receive under the Program.
- 3) Contact my doctor, healthcare provider, or pharmacist about my application for the Program, and disclose to them information contained in my application.
- 4) Request information from my insurer, doctor, healthcare provider, or pharmacist about the prescribed medications I receive or will receive under the Program and about my medical condition. By signing below, I also authorize my insurer, doctor, healthcare provider, or pharmacist to release information about my prescribed medications and medical condition that is requested.
- 5) Contact my insurer and other potential funding sources on my behalf in order to determine if I am eligible for health insurance coverage or other funds, and disclose to them information contained in my Program application or information about my prescribed medications and medical condition that has been provided by my physician, healthcare provider, or pharmacist.
- 6) I understand that this Authorization to Release and Disclose Medical Information will remain in effect for as long as I participate in the Program and for a period of 3 years after my participation in the Program ends. Furthermore, I certify that the information provided in this application is complete and accurate to the best of my knowledge and agree to notify Xubex of any change in my insurance eligibility.

Applicant Signature _____

Date _____

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