PO Box 42678
Baltimore, MD 21284
(Fax) 410-821-9265

MEDBANK of Maryland, Inc.

WHAT DOES MEDBANK DO?

- MEDBANK is a non-profit organization that provides access to free medications for patients who are uninsured or underinsured and meet the financial guidelines
- MEDBANK gathers all of the required information from the patient and the physician and completes and sends application to the drug companies for approval.
- The drug companies require proof of the patient's income to be attached to the applications for free medications.
- All information collected by MEDBANK is treated as private and confidential.

WHAT HAPPENS NEXT?

- If the drug company approves the patient, in most cases they send a three-month supply of medications directly to his/her doctor's office.
- The patient picks up his/her medicine at the doctor's office.

HOW LONG WILL IT TAKE BEFORE I RECEIVE MEDICATIONS?

- From the time MEDBANK receives the patient's paperwork it will typically take 4-6 weeks before receiving the first supply of medications.

HOW DO I RECEIVE A SECOND SUPPLY OF MEDICATIONS?

- When a patient picks up a medicine from his/her doctor's office it is very important that they call MEDBANK and report the name of the medicine they received, the quantity they received and the date it was received**.**
- The toll free number is **1 877-435-7755**. The local number is **410 –821-9262.**
- MEDBANK will enter the information on the medication received into their computer system
- MEDBANK will automatically complete applications every three months if the patient has called and reported that they received medicines.

If a patient does not call when they receive medications, MEDBANK will not know when to redo the application. The patient will not receive their next supply of medications.

PLEASE CALL MEDBANK EACH TIME YOU RECEIVE MEDICINE

The bridge to brighter days ahead.
www.medbankmd.org

Revised November, 2005

MEDBANK of Maryland, Inc.

HOW DO I ENROLL IN THE MEDBANK PROGRAM?

You must first call MEDBANK to see if you may be eligible for the program. (**the toll-free number is 1 877 435-7755, the local number is 410 821-9262)**) A referral packet containing several forms for you to complete and one form for your doctor to complete will be mailed to you.

YOU WILL NEED TO COMPLETE:

1. The three-page Patient Questionnaire Form (**every blank must be completed**)
2. The Consent to Exchange Information and Signature Form (you must sign in **two** places on this form)
3. 4506-T Form. Please sign and fill out the areas that are checked. This form is verification that you did **not** file an income tax return. It is required by several of the drug companies. If you **did** file an income tax return, please do not complete this form.

You must also include copies of proof of income. If you are married, you must also send copies of your spouse's income. Proof of income may be one of the following:

1. If you file income tax, a copy of your most recent tax return (**year 2005**). Do ***not*** send a 1099 form – the drug companies do not accept this as proof of income.
2. If you do not file income tax, a copy of your Social Security Benefit letter for **2006** and/or pension statements
3. If you do not have your benefit letter, you may send a copy of your most recent bank statement showing direct deposits of your social security check or pension income.
4. If you are working and your income is from wages earned, you must send copies of your pay stubs from the **last three months.**

The drug companies require these specific documents as current proof of income. MEDBANK must attach copies of your income to the applications we send to the drug companies. **Without complete proof of income we cannot process your applications.**

Take your completed three- page patient questionnaire, signed consent form, form 4506-T, copies of your proof of income and the Physician Referral form to your doctor's office and ask them to complete the Physician form. **Your doctor's office must complete the Physician Referral form.**

Either the doctor's office or the patient can fax or mail **all** of the information **together.**

MAILING ADDRESS: **MEDBANK of Maryland, Inc.**
P. O. Box 42678
Baltimore, MD 21284

FAX NUMBER: 410 821-9265

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MARYLAND RESIDENTS ONLY

PLEASE READ

IMPORTANT INCOME INFORMATION

FOR A PATIENT TO BE ELIGIBLE FOR THE MEDBANK PROGRAM, THEY MUST HAVE AN INCOME OF AT LEAST $948.01 PER MONTH FOR ONE PERSON IN THE HOUSEHOLD AND $1100.01 FOR TWO PEOPLE IN THE HOUSEHOLD.

IF THE PATIENT'S INCOME IS LESS THAN $948.01* PER MONTH FOR ONE PERSON IN THE HOUSEHOLD – OR LESS THAN $1100.01* PER MONTH FOR TWO PEOPLE IN THE HOUSEHOLD, THE PATIENT MUST FIRST CALL MARYLAND PHARMACY ASSISTANCE FOR HELP WITH THEIR MEDICATIONS. (1-800-226-2142)

IF YOU HAVE APPLIED FOR MEDICAID OR MARYLAND PHARMACY ASSISTANCE AND HAVE BEEN TURNED DOWN, YOU MAY APPLY TO MEDBANK.

* Income Guidelines subject to change by the MPAP

TO THE PHYSICIAN:

MEDBANK of Maryland, Inc. is a non-profit organization whose mission is to provide access to free medications from the patient assistance programs offered by the pharmaceutical companies. MEDBANK has been in operation since February 2000 and has provided over 67 million dollars worth of free medications to residents in the state of Maryland. We are now offering our program to patients throughout the United States. We work with over 100 different pharmaceutical companies who each have their own unique application and financial guidelines. We take responsibility for gathering all of the required information from the patient and the physician. We complete applications and submit them to the drug companies on behalf of the patient.

When the applications are approved, generally a 90-day supply of medications are shipped from the pharmaceutical company directly to their physician's office. The patient picks up their medications at their doctor's office.

MEDBANK is responsible for completing applications to the pharmaceutical companies every three-months in order for the patient to continue receiving their free medications.

Your patient has contacted us for medication assistance. We ask that you complete the physician referral form for your patient. Please prescribe only brand name medications. The pharmaceutical companies do not have generic medications on their patient assistance programs. A formulary listing the drugs available is included for your convenience.

Either the doctor's office or the patient can fax or mail all of the information together. If you have any questions, please feel free to call us toll-free at 1 877-435-7755 or locally at 410 821-9262.

MEDBANK of Maryland, Inc.

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P. O. Box 42678
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FAX NUMBER: 410 821-9265

PRINT OR TYPE ONLY

Patient Questionnaire

NEW MEDBANK Patient Only

Toll free Number: 1 877-435-7755 Fax: 410 821-9265

Local Number: 410 –821-9262

MEDBANK OF MARYLAND, INC.™

The bridge to brighter days ahead.

What is your…

Last name? _____

First name? _____

Middle name? _____

Phone number? _____

Street address? _____

Apartment number? _____

City? _____

State? _____

Zip code? _____

Maryland County? _____

E-mail address? _____

Date of birth? _____

Social Security Number? _____

Primary language spoken? ❑ English ❑ Spanish ❑ Other: _____

Gender? ❑ Male ❑ Female

Race? ❑ African American ❑ Asian ❑ Hispanic ❑ American Indian ❑ Caucasian ❑ Other _____

Marital Status? ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

How many people live in your household? _____

How many people do you claim as dependants on your Tax Returns? _____

Does anyone claim you on his or her Tax Returns? _____

Who is your primary care provider or family doctor? _____

What is the name of his/her private practice/clinic/hospital? _____

What is his/her phone number? _____

How did you hear about MEDBANK? _____

Are you a US Citizen or legal resident? ❑ Yes ❑ No

Patient Questionnaire

Do you receive money from any of the following? If yes, please indicate how much you receive each month. If you receive income from a source not listed below, please specify the source under "Other."

Supplemental Social Security	❑ No	❑ Yes	Monthly Amount	$ _____
Disability	❑ No	❑ Yes	Monthly Amount	$ _____
Pension	❑ No	❑ Yes	Monthly Amount	$ _____
Unemployment	❑ No	❑ Yes	Monthly Amount	$ _____
Social Security	❑ No	❑ Yes	Monthly Amount	$ _____
Alimony or Child Support	❑ No	❑ Yes	Monthly Amount	$ _____
Salary or wages	❑ No	❑ Yes	Monthly Amount	$ _____
Other: _____	❑ No	❑ Yes	Monthly Amount	$ _____
_____	❑ No	❑ Yes	Monthly Amount	$ _____

Please indicate if you have any of the following medical expenses. If you do, please indicate how much you pay each month. If you have other medical expenses, please specify them under "Other."

Prescription Medications	❑ No	❑ Yes	Monthly Amount	$ _____
Lab Fees	❑ No	❑ Yes	Monthly Amount	$ _____
Office Visits	❑ No	❑ Yes	Monthly Amount	$ _____
Other: _____	❑ No	❑ Yes	Monthly Amount	$ _____
_____	❑ No	❑ Yes	Monthly Amount	$ _____

Do you have any of the following assets? If yes, please indicate their current value. If you have any assets not listed below please specify them under "Other."

Stocks and/or Bonds	❑ No	❑ Yes	Current Value	$ _____
Certificates of Deposit (CDs)	❑ No	❑ Yes	Current Value	$ _____
Checking Account	❑ No	❑ Yes	Current Value	$ _____
Savings Account	❑ No	❑ Yes	Current Value	$ _____
Individual Retirement Accounts (IRAs)	❑ No	❑ Yes	Current Value	$ _____
Annuities	❑ No	❑ Yes	Current Value	$ _____
Other: _____	❑ No	❑ Yes	Monthly Amount	$ _____
_____	❑ No	❑ Yes	Monthly Amount	$ _____

Patient Questionnaire

Please complete the following information about your health insurance.

Primary Insurance Policy: _____ Policy Number: _____

Secondary Insurance Policy: _____ Policy Number: _____

Do you have insurance that covers Prescriptions? ❑ Yes ❑ No

If yes, how much is covered per year? $ _____

Have you reached this limit? ❑ Yes ❑ No If yes, when? _____

When will you have coverage again? _____

Do you have Medicare Coverage? ❑ Yes ❑ No Medicare Number: _____

Do you have Medicaid Coverage? ❑ Yes ❑ No

Do you have Veterans Assistance? ❑ Yes ❑ No

Do you use any pharmaceutical company discount cards? ❑ Yes ❑ No

If yes, which one(s)? _____

As far as you know, are you allergic to any medications? ❑ Yes ❑ No

If yes, please list: _____

When was your last…

Office Visit? Date: _____ Reason: _____

Stay in the hospital? Date: _____ Reason: _____

Emergency room visit? Date: _____ Reason: _____

Optional: Please complete the following information if there is an *alternative* contact (family member, social worker, etc.) that we should communicate with.

Last name: _____

First name: _____

Street Address: _____

Suite/Apartment Number: _____

Phone Number: _____

City: _____

State: _____

Zip code: _____

Relationship to Patient: _____

Should this be our primary contact? ❑ Yes ❑ No

If yes, please indicate why: _____

Personal information received will be treated with confidentiality and viewed only by MEDBANK personnel. The patient may inspect information we have on file at any time and request that changes be made.

CONSENT TO EXCHANGE INFORMATION

I authorize **MEDBANK of Maryland, Inc. to:**

1. Obtain pertinent information, when needed. to solicit medications on my behalf from companies that manufacture or provide them through the patient assistance programs.
2. Discuss me and my medical needs with my physician/prescriber, whenever necessary
3. Verify my income through any government agency, employer, company, business, and/or organization from which I receive income.

*This authorization is binding for a period of **one year** from the date this document is signed, and for as long as MEDBANK is assisting me, **or** until I revoke my cons*ent. *I also agree that a copy of this form can be accepted as a valid consent to share information. Moreover, I understand that if I do not sign this form, information will not be shared, and I will have to contact each agency, company, or organization individually to give them the information about me that they need.*

DOB: _____ Social Security Number: _____

Address: _____

Printed Name Of Patient: _____

Signature: _____ Date: _____

SIGNATURE AUTHORIZATION

I authorize **MEDBANK of Maryland, Inc to:**

1. Provide information to **and** sign forms on my behalf for the purpose of soliciting medications on my behalf from companies that manufacture or provide these medications through patient assistance programs
2. Ship these medications, when necessary, to my current physician/prescriber's designated facility for pick-up.

*This signature authorization is binding for a period of **one year** from the date this document is signed, and for as long as MEDBANK is assisting me **or** until I revoke my consent.*

Full Printed Name Of Patient: _____

Signature: _____ Date: _____

AUTHORIZED REPRESENTATIVE (**OPTIONAL)**

I authorize **MEDBANK of Maryland, Inc. to communicate with the following friend, family member, or other personal representative on my behalf, as necessary:**

Name Of Designated Representative: _____

Signature: _____ Date: _____

PRINT OR TYPE ONLY

Physician/Prescriber Referral for Medications

NEW MEDBANK Patient Only

Local Number: 410-821-9262

Toll free: 1 877-435-7755 Fax: 410-821-9265

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The bridge to brighter days ahead.

PHYSICIAN/PRESCRIBER COMPLETES THE FOLLOWING:

Referral Date:	Who can answer questions about this referral?
Name of Clinic/Hospital associated with this referral:	

Patient Last Name _____ First Name _____ Social Security Number _____

PHYSICIAN/PRESCRIBER INFORMATION

Last Name:	First Name:		MI:
Specialty:	Title:	DEA#:	Exp:
State License #:	State:	Exp:	UPIN #:
Address:			
Suite/Building:	E-mail Address:		
City:	State:	Zip:	
Office Contact:	Phone #:	Fax #:	

MEDICATION INFORMATION:

BRAND NAME MEDICATION (Do not list generics)	DOSAGE	FREQUENCY	DIAGNOSIS

Please indicate below if you wish correspondence or medications directed to an alternate address:
Direct all Physician/Prescriber correspondence to:

Ship Medications to: _____

Prescriber's above address or other office location.

Prescriber's Signature: _____ Date: _____

Personal information submitted will be treated with confidentiality and viewed only by MEDBANK personnel.