



NEW APPLICATION

RE-ENROLLMENT APPLICATION

CHANGES TO EXISTING APPLICATION

Please note: All fields must be completed (unless noted as optional) or application will be returned.

LAST NAME		FIRST NAME				MI
GENDER		DATE OF BIRTH		SOCIAL SECURITY NUMBER		
Male	Female		-			
# OF PEOPLE IN HOUSEHOLD		YEARLY HOUSEHOLD INCOME (PLEASE ENTER AN AMOUNT)		PHONE NUMBER (WRITE N/A IF YOU DO NOT HAVE A PHONE)		
HOUSE ADDRESS		CITY	STATE	ZIP	COUNTY	
MAILING ADDRESS (IF DIFFERENT FROM ABOVE):		CITY	STATE	ZIP	COUNTY	
RACE (FOR TITLE VI PURPOSES):				LANGUAGE SPOKEN (OPTIONAL)		
Black	American Indian or Alaskan		English			
White	Hispanic		Spanish			
Asian or Pacific Islander	Other: _____		Other: _____			
Yes	No	ARE YOU A U.S. CITIZEN OR QUALIFIED LEGAL ALIEN?				
Yes	No	HAVE YOU LIVED IN TENNESSEE FOR AT LEAST THE LAST SIX MONTHS?				
Yes	No	DO YOU HAVE HEALTH INSURANCE (INCLUDING TENNCARE)?				
Yes	No	DO YOU HAVE ANY PRESCRIPTION DRUG COVERAGE OTHER THAN COVERRX? THIS INCLUDES MEDICARE, TENNCARE OR DRUG COVERAGE PROVIDED BY YOUR EMPLOYER. (DISCOUNT DRUG PROGRAMS OR PATIENT ASSISTANCE PROGRAMS PROVIDING FREE OR LOW-COST MEDICATIONS DO NOT COUNT.)				
Yes	No	DO YOU HAVE MEDICARE (ANY PART INCLUDING A, B, C, OR D)?				
Yes	No	ARE YOU HOMELESS OR LIVING IN A SHELTER? (OPTIONAL)				
Yes	No	ARE YOU EMPLOYED (INCLUDING SELF-EMPLOYED)? (OPTIONAL)				
Yes	No	DO YOU WORK 20 HOURS OR MORE IN A SEVEN DAY WORK WEEK? (OPTIONAL)				

Terms and Conditions

While you are in CoverRx, you must follow the program rules. By signing the front of this form, you agree that:

- You will pay your co-pay for each prescription filled.**
- You will notify CoverRx by submitting an updated application when:**
 - You move to a new address
 - Your household income changes significantly
 - The number of people in your household changes
 - You have other prescription drug coverage

Form Number
TNCX0216

You will help with any investigations. CoverRx may ask you for proof of your household income. CoverRx may also ask you to provide proof that you live in Tennessee and/or that you are a U.S. citizen or qualified alien. You agree to provide this information to CoverRx. If you do not help, then you could lose your pharmacy assistance.

You allow CoverRx to get information about you. I understand that I have certain privacy rights with respect to my medical information under the Health Insurance Portability and Accountability Act (HIPAA), CFR Parts 160 and 164 ("Privacy Rule"). The Privacy Rule permits CoverRx to use and disclose my protected health information for purposes of treatment, payment and health care operations, including determining my eligibility for benefits.

You can report fraud or abuse. If you suspect someone of fraud or abuse please call Magellan Health Services at 1-800-424-5815.

Authorization: I want to apply for CoverRx pharmacy assistance. By signing below, I certify that the information contained in the application is true and accurate. I know that if I give any false information, I may be breaking the law. I know that CoverRx will check my information. I agree to help with any investigations. I also agree to follow the rules for the CoverRx program. I have read and understand these rules, which are on the back of this form.

Signature: _____ Date: _____

Eligibility

To be eligible to participate in CoverRx, you must meet the following eligibility guidelines:

- Age 19 through 64
- Household income must be below the FPL income guidelines listed below
- U.S. citizen or qualified alien
- Tennessee resident for at least the last six months
- No prescription drug coverage including TennCare or employer-sponsored drug coverage. (Discount drug programs or patient assistance programs providing free or low cost medications do not count.)
- Cannot have Medicare (any part including A, B, C or D)

How Much You Will Have to Pay

If you are enrolled, CoverRx will help you pay for up to five prescriptions each month. Diabetic supplies and insulin do not count toward the prescription limit. You must pay a small co-payment for your first five prescriptions each month. (Note: A 90-day prescription will count as one prescription per month for three consecutive months.) Co-pay ranges are listed in the table to the right. If enrolled, your exact co-payments will be included in your welcome packet.

Co-payments are subject to change.

Type of Prescription	What You Will Pay
First five (5) prescriptions per month of Drugs on the <i>CoverRx Covered Drug List</i> . Diabetic supplies and insulin do not count against the five (5) script limit.	<p>Generic Drugs: 30-day = \$3 *90-day = \$5</p> <p>Brand Drugs: 30-day = \$5</p> <p>Insulin/Diabetic Supplies: 30-day (or up to covered limits) = \$5</p> <p>*90-day supplies are only available through mail order and those local retail pharmacies that have chosen to participate. Before you fill your prescription, check with your pharmacy to see if the 90-day supply is not available for covered brand drugs and covered insulin.</p>
<ul style="list-style-type: none"> • Drugs NOT on the <i>CoverRx Covered Drug List</i> • ALL prescriptions after the five (5) prescription per month limit 	Full price (price varies by drug), plus any pharmacy discounts available.

- You can purchase your prescriptions at participating local community retail pharmacies and mail-order pharmacies.
- Upon enrollment in CoverRx, a welcome packet will be sent to you with information about how to use the program.

Income Guidelines

To qualify for the CoverRx program, your yearly household income must be below the FPL levels listed in the table to the right.

Based on 2016 federal poverty guidelines. For families/households with more than 8 persons, add \$4,160 for each additional person.

Persons in Household	Yearly Household Income
1	\$11,880
2	\$16,020
3	\$20,160
4	\$24,300
5	\$28,440
6	\$32,580
7	\$36,730
8	\$40,890

Contact Information

Mail or fax completed form to: Tennessee CoverRx
Magellan Health Services
P.O. Box 1808
Maryland Heights, MO 63043
1-800-424-5766 (Fax)

For questions about enrolling in CoverRx: 1-800-424-5815 (Phone)

Definitions

“Discount” means a price reduction offered to participants for certain prescriptions.

“Household Income” is the combined income of all household members 18 years old and over who maintain a single economic unit, as well as any income received by the household for the personal medical and other obligations of the participant(s) in the household.

“Household” is comprised of all persons living in the same residence maintaining a single economic unit.

“Qualified alien” means that you are not a U.S. citizen, but you live in the United States legally. To be a qualified alien, you must also meet other conditions. These conditions are defined in the federal law at 8 U.S.C. § 1622(b). If you are not a U.S. citizen or qualified alien, then you cannot enroll in CoverRx.