



Tennessee CoverRx
OptumRx, Inc.
P.O. Box 2135

Mission, Kansas 66201 Fax: 1-800-424-5766



NEW APPLICATION ☐ RE-ENROLLMENT APPLICATION

Please note: All fields must be completed (unless noted as optional). Please see above to mail or fax completed form.							
LAST NAME			FIRST NAME				мі
GENDER DATE OF BIRTH SOCIAL SECURITY NUMBER							
☐ Male ☐ Female	_	-			_		
# OF PEOPLE IN HOUSEHOLD	YEARLY HOUSEHO	OLD INCOME (PLEASE ENT	TER AN AMOUNT)	НОМЕ Р	PHONE NUMBER (WRITE N/A IF	YOU DO NOT HAVE A PHO	NE)
					_	-	
EMAIL ADDRESS				CELL PHONE NUMBER (WRITE N/A IF YOU DO NOT HAVE A PHONE)			
					-	-	
В					nt to the phone number	er	
listed above. You may opt out of text messages upon receipt of first message.							
HOUSE ADDRESS		CITY		STATE	ZIP	COUNTY	
MAILING ADDRESS (IF DIFFERENT FI	ROM ABOVE):	CITY		STATE	ZIP	COUNTY	
RACE (FOR TITLE VI PURPOSES):				LANGUAGE SPOKEN (OPTIONAL)			
Black				☐ Engli:	sh		
White	Hispanic			Spanish			
Asian or Pacific Islander Other:				Othe	r:		
Yes No ARE YOU A U.S. CITIZEN OR QUALIFIED LEGAL ALIEN?							
Yes No HAV	Yes No HAVE YOU LIVED IN TENNESSEE FOR AT LEAST THE LAST SIX MONTHS?						
Yes No DO	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	DO YOU HAVE MEDICARE (ANY PART INCLUDING A, B, C, OR D)?						
Yes No ARE	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





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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 OptumRx 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:	
	_	





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Eligibility

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

- Age 18 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 employersponsored 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 copayment 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.

Co-payments are subject to change.

Type of Prescription	What You Will Pay		
First five (5) prescriptions per month of	Generic Drugs: 30-day = \$3		
Drugs on the CoverRx Covered Drug List.	*90-day = \$5		
Diabetic supplies and insulin do not count against the five (5) script limit.	Brand Drugs: 30-day = \$5		
against the five (5) stript limit.	Insulin/Diabetic Supplies:		
	30-day (or up to covered limits) = \$5		
	*90-day supplies are only available through mail		
	order.		
Drugs NOT on the CoverRx Covered	Full price (price varies by drug), plus any		
Drug List	pharmacy discounts available.		
ALL prescriptions after the five (5)			
prescription per month limit			

- 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 2024 federal poverty guidelines. For families/households with more than 8 persons, add \$5,380 for each additional person.

Persons in Household	Yearly Household Income
1	\$20,783
2	\$28,207
3	\$35,632
4	\$43,056
5	\$50,480
6	\$57,905
7	\$65,329
8	\$72,754

Contact Information

Mail or fax completed form to: Tennessee CoverRx

OptumRx
P.O. Box 2135
Mission, Kansas 66201
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.

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Do you need free help with this letter?

If you speak a language other than English, help in your language is available for free. This page tells you how to get help in a language other than English. It also tells you about other help that's available.

Spanish: Español

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-259-0701 (TTY: 1-800-848-0298).

Surdish: مدروک

ى راداڭائ: رەگەن مە ينامز ىدروك ئىمكەد مىسەق، يناكەن رازوگىئەمزخ ئىئەمراى ئىزارۆخەب ،نامز، ۋب ۋئ مىسەدر مە. ئىدنەۋ ئامە مە TTY (2-800-848-0298) - 259-0701

Arabic: ربيةعلا

وظة حلم: اذا ملكت قائلاً ربية علا اتمد خدة عاسما ويقائلاً وقوتم ك انجام. اتصل مقبر:0701-259-858-1 وظة حلم: 1-808-848-259 مقر فتاه صما و مكباً:808-848-1-800-848

Chinese: 繁體中文

注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 1-855-259-0701 (TTY 1-800-848-0298)。

Vietnamese: Tiếng Việt

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-259-0701 (TTY: 1-800-848-0298).

Korean: 한국어

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-259-0701 (TTY: 1-800-848-0298) 번으로 전화해 주십시오.

French: Français

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-259-0701 (ATS : 1-800-848-0298).

Amharic: አማርኛ

ማስታወሻ: የሚናንሩት ቋንቋ ኣማርኛ ከሆነ የትርንም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-259-0701 (ውስማት ለተሳናቸው: 1-800-848-0298).

Gujarati: ગુજરાતી

સુયન**ાઃ જ**ો તમે ગ**ુજરાતી બ**ોલતા હ**ો, તો નનઃશ**ુલ્ક ભ**ાષ**ા સહાય સેવ**ાઓ તમ**ારા મ**ાટ** ઉપલબ**્ધ છ**ે.

ફ**ોન** કરો

1-855-259-0701 (TTY: 1-800-848-0298).

Laotian: ພາສາລາວ

ໂປດຊາບ: ຖາວາ ທານເວາພາສາ ລາວ, ການພໍລຶການຊວຍເຫອດານພາສາ, ໂດຍບເສງຄາ, ແມນມພອມໃຫທານ. ໂທຣ 1-855-259-0701 (TTY: 1-800-848-0298).

German: Deutsch

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-259-0701 (TTY: 1-800-848-0298).

Tagalog: Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-259-0701 (TTY: 1-800-848-0298).

Hindi: ह दी

ध्यान दें: यदद आप ६ दी बोलत तो आपक दलए मफ्त में भाषा स ायता सवाए उपलब्ध । 1-855-259-0701 (TTY: 1-800-848-0298) पर कॉल कर।





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Serbo-Croatian: Srpsko-hrvatski

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-259-0701 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-848-0298).

Russian: Русский

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-259-0701 (телетайп: 1-800-848-0298).

Nepali: नपाली

Health Care Finance and

ध्यान ददन ोस: तपार्इल नपाली बोल्नहुन्छ भन तपार्इको दनम्ति भाषा स ायता सवा रूदिनीशल्क रूपमा उपलब्ध छ । फोन गन ोस 1-855-259-0701 (दिदिवार्इ: 1-800-848-0298) ।

Persian:

هجوت: رگا هه نابز یسران یم وگننگ دیزک، بنابز تلایهت تسروص؛ ناگنیار امش یارب یم مهارف دشاب اب (TTY: 1-800-848-0298) بیارت کاری سامهٔ نگب د بر.

OptumRx

- Do you need help talking with us or reading what we send you?
- Do you have a disability and need help getting care or taking part in one of our programs or services?
- Or do you have more questions about your health care? Call us for free at 1-855-259-0701. We can connect you with the free help or service you need. (For TTY call: 1-800-848-0298)

We obey federal and state civil rights laws. We do not treat people in a different way because of their race, color, birth place, language, age, disability, religion, or sex. Do you think we did not help you or you were treated differently because of your race, color, birth place, language, age, disability, religion, or sex? You can file a complaint by mail, by e-mail, or online. Here are three places where you can file a complaint:

U.S. Department of Health &

		O P ********
Administration	Human Services	Compliance & Ethics HelpCenter
Office of Civil Rights	Office for Civil Rights	Corporate Compliance
Compliance	200 Independence Ave SW, Rm	Department
310 Great Circle Road, Floor	509F, HHH Bldg	
4W	Washington, DC 20201	
Nashville, Tennessee 37243	Phone: 800-868-1019	Phone: 800-455-4521
Email:	(TDD): 800-537-7697	Email:
1		
HCFA.Fairtreatment@tn.gov	You can get a complaint form	Govcompliance@uhc.com
Phone: 855-857-1673	online at:	
(TRS 711)	https://hhs.gov/ocr/complaints/	
You can get a complaint	index.html	
form online at:	Or you can file a complaint	
http://www.tn.gov/hcfa/article/	online at:	
civil-rights-compliance	https://ocrportal.hhs.gov/ocr/portal/	
	<u>lobby.jsf</u>	