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	MI

GENDER ☐ Male ☐ Female

DATE OF BIRTH ☐☐ – ☐☐ – ☐☐☐☐

SOCIAL SECURITY NUMBER ☐☐☐ – ☐☐ – ☐☐☐☐

# OF PEOPLE IN HOUSEHOLD	YEARLY HOUSEHOLD INCOME *(PLEASE ENTER AN AMOUNT)*	HOME PHONE NUMBER *(WRITE N/A IF YOU DO NOT HAVE A PHONE)*
		☐☐☐ – ☐☐☐ – ☐☐☐☐

EMAIL ADDRESS	CELL PHONE NUMBER *(WRITE N/A IF YOU DO NOT HAVE A PHONE)*
	☐☐☐ – ☐☐☐ – ☐☐☐☐

By signing below, you agree to receive CoverRx text-messages sent to the phone number listed above. You may opt out of text messages upon receipt of first message.

HOUSE ADDRESS	CITY	STATE	ZIP	COUNTY

MAILING ADDRESS *(IF DIFFERENT FROM ABOVE)*:	CITY	STATE	ZIP	COUNTY

RACE *(FOR TITLE VI PURPOSES)*:

☐ Black ☐ American Indian or Alaskan
☐ White ☐ Hispanic
☐ Asian or Pacific Islander ☐ Other:

LANGUAGE SPOKEN (OPTIONAL)

☐ English
☐ Spanish
☐ 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

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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 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.

Co-payments are subject to change.

Type of Prescription	*What You Will Pay*
First five (5) prescriptions per month of Drugs on the *CoverRx Covered Drug List.* Diabetic supplies and insulin do not count against the five (5) script limit.	*Generic Drugs:* 30-day = $3 *90-day = $5 *Brand Drugs:* 30-day = $5 *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 Drug List* • 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 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).

Kurdish: **کوردی**

ئاگادارى: ئەگەر بە زمانى كوردى قسە دەكەيت خزمەتگوزارىيەكانى يارمەتىدانى زمان، بەخۆڕاىى بۆ تۆ بەردەستە. پەيوەندى بكە بە TTY (1-800-848-0298(1- 855-259-0701.

Arabic: **ربيةعلا**

وظةحلم: اذا ملكتت ةغللا ربيةعلا اتمدخ دةعاسملا ويةغللا رةفوتم لكل انجام. اتصل مقبر:1-855-259-0701
مقر فتاه صملا و مكبلا:1-800-848-0298

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: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-259-0701 (መስማት ለተሳናቸው: 1-800-848-0298).

Gujarati: **ગુજરાતી**

સુચન ા: જ ો તમે ગુજરાતી બ ોલતા હ ો, તો મન:શુલ્ક ભ ાષ ા સહ ાય સેવ ાઓ તમ ારા મ ાટ ઉપલબ્ ધ છ ે.
ફ ોન કરો
1-855-259-0701 (TTY: 1-800-848-0298).

Laotian: **ພາສາລາວ**

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສຍຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 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 ंद ी**

ध्यान द ें: यदद आप द ी ब ोलत तो आपक दलए मफ्त मे ं भाष ा स ायता सवाए उपलब्ध । 1-855-259-0701 (TTY: 1-800-848-0298) पर क ॉल 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: **नप◌ाल◌ी**
ध्यान ददन ◌ोस: तप◌ाइ्इल नपाल◌ी ब◌ोल्◌नहुन्छ भन तप◌ाइ्इक◌ो दनम्ति भाष◌ा स ◌ायता सवा रू दनीशल्क रूपमा उपलब्ध छ । फ◌ोन गन ◌ोस 1-855-259-0701 (दिदिवाइ्इ: 1-800-848-0298) ।

Persian:
هجوت: رگا هب نابز یسراف یم وگتفگ دینک، ینابز تلایهست تروصب ناگیار امش یارب یم مهارف دشاب. اب 1-855-259-0701 (TTY: 1-800-848-0298) سامت یگب د یر.

- **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:

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