



450 West Monroe Street, Wytheville, VA 24382

Phone: 276-223-0558 Fax: 276-223-0015

Website: www.brockhughes.org

Office Hours: Monday-Thursday 8am-4:30pm and Friday 8am-1:00pm

Medication Assistance Program (MAP)

**If you are having trouble affording your medications,
insured or not, BHMC CAN HELP!**

Who Qualifies?

**Residents of Virginia, with or without insurance, including those with
Medicare Part D**

You DO NOT have to be a patient at Brock Hughes Medical Center

What We Will Need for You to Do:

1. Complete the application
2. Collect the following to bring to our office
 - Most recent taxes, W-2's or 1099, pension statements, letters from the Social Security Administration, one month's worth of most recent paystubs, or unemployment statement.
 - Written prescription or prescriptions from your doctor's office for a 1 year supply
 - All current insurance card(s)
 - Copy of any Prior Authorization denials that have been processed by your doctor's office
 - If you have Medicare Part D, we may require more documentation

**Teresa Gilman, Pharmacy Tech, is who you can speak to if you have any questions.
tgilman@brockhughes.org or call 276-223-0558, ext 2.**

What Happens After I Turn in my medications to BHMC?

- BHMC staff will complete all necessary paperwork & handle all phone calls for you with each individual pharmaceutical company.
- Once approved, your medication will be supplied from the pharmaceutical company in 90 or 120 day increments.
- Your medication will be shipped to the clinic to pick up at your convenience or to your home. **For medications shipped to BHMC there is a \$7.00 processing fee.**
- You will need to let Teresa know when you are down to a 30-day supply of your medication(s) so she can order your refills(s).
- Paperwork will need to be completed once a year for continuation in the program.



Brock Hughes
Medical Center

10 Most Common
Prescriptions We Can
Assist **YOU** With:

Farxiga

\$1,667.28

Ozempic

\$3,697.80

Vraylar

\$4,142.19

Ubrelvy

\$2,958.54

Eliquis

\$1,702.05

Breztri

\$1,847.37

Trulicity

\$3,731.80

Rexulti

\$4,213.74

Qulipta

\$3,128.61

Dexilant

\$883.08





Brock Hughes
Medical Center

Medication Assistance Program

PATIENT DEMOGRAPHIC FORM

Name (First, Middle, Last): _____

Date of Birth: _____ Social Security Number: _____

Street Address OR P.O. Box: _____

City, State & Zip Code: _____

Email Address: _____

Home Phone: _____ Cell Phone: _____

Can we leave a message on your voicemail (circle one)? YES or NO

Preferred Method of Contact (circle one): Home Phone Cell Phone Text Message Email

Gender: _____ Ethnicity (circle one): Hispanic OR Non-Hispanic

Race (circle one): African-American Asian White Native American Pacific Highlander Hispanic Other

Marital Status: _____ Citizenship Status (circle one): U.S. Citizen U.S. Resident Other

Are you a United States Veteran (circle one)? Yes or NO

Primary Language: _____ Do you require an interpreter (circle one)? Yes OR NO

Circle One: Insured or Uninsured

Any Medication Allergies? Please list: _____

Total Number in Household, including you: _____

Name, Relationship, Age

By signing below, I acknowledge that the above information is true and accurate to the best of my knowledge. I agree to inform Brock Hughes Medical Center if my household size, income or insurance status changes.

Patient Signature: _____ Date: _____

How did you hear about the BHMC Medication Assistance Program? _____



Medication Assistance
Program

**PATIENT MEDICATION ASSISTANCE PROGRAM
SIGNATURE WAIVER**

I, _____, certify that the information I have supplied Brock Hughes Medical Center is accurate to the best of my knowledge and I hereby authorize the Patient Medication Assistance Coordinator as designated Patient Medication Assistance Advocate to sign my name on the necessary pharmaceutical form(s) that may be required for ordering my needed medication(s). I also give permission for this person to speak to the necessary doctor's offices and pharmaceutical companies. These medications are free; however, there is a minimal processing fee for costs associated with pharmacy supplies and staff.

Patient Signature

Date