

**WellSpring Pharmaceutical Patient Assistance Program**

***P.O. Box 801  
Somerville, NJ 08876  
(908) 203-3791***

- 1. Original application must be completed in its ENTIRETY.**
  - 2. Practitioner must sign and date application.**
  - 3. Attach original prescription (signed by prescribing Practitioner) for a 3 month supply.**
  - 4. Patient or authorized representative must sign and date completed application and HIPAA release form.**
  - 5. Required supporting documentation includes:**
    - \* Proof of ALL household income (most recent federal tax return 1040, Social Security SSA 1099, pensions, interest, etc.). If you do not file a federal tax return, please call 1-908-203-3791 for instructions.
    - \* Dated letter from Medicaid verifying current coverage.
    - \* The patient must submit a signed letter stating the patient has no prescription coverage.
    - \* Copy of insurance card(s) (Private, Medicare, Supplemental and/or Medicaid)
    - \* Provide a written statement from the patient's insurance company, private or supplemental, and/or Medicaid office stating the patient has no prescription coverage (if applicable).
- \* Application, HIPAA release form, prescription and required documentation must be mailed to the above address.**
- \* If patient is approved for the program, product will be shipped directly to the office of Practitioner.**
- \* Any questions, please call 1-908-203-3791.**





WellSpring Pharmaceutical Corporation

Health Insurance Portability and Accountability Act (HIPAA) compliance:

By signing the authorization below, you agree to:

I authorize WellSpring Pharmaceutical and their authorized agent(s) to use the information on this application to process my request for medication from the WellSpring Patient Assistance Program and authorize the use of my Social Security number for identification purposes and record keeping. I further authorize WellSpring to use the information contained on this form to contact me or my healthcare provider to review my eligibility for the program, and to confirm receipt of medications. I agree that I will contact the WellSpring Patient Assistance Program if any of the information regarding prescription drug coverage or insurance changes. I understand that I may revoke this consent and withdraw from participation in the program at any time by calling (908) 203-3791. I understand that my prescribing physician is responsible for choosing which prescription products are right for me, and that WellSpring is not responsible for verifying my medical condition or my prescribing physician's selection of products.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*5911 North Honore Ave, Ste 211  
Sarasota, FL 34243*

*Tel: 941.312.4727  
Fax: 941.312.4738  
email: [wsp@wellspringpharm.com](mailto:wsp@wellspringpharm.com)*