



MCKENNA
NEW BRAUNFELS

Prescription Access Application

1. Fill in your physician's information:

Physician's Name: _____

Physician's Phone: _____
NEW BRAUNFELS PHYSICIANS ONLY

2. Fill in your basic information:

Name: _____
FIRST, MIDDLE INITIAL, LAST

Address: _____
NUMBER, STREET

Address: _____
CITY, STATE, ZIP

Phone: _____

Number in Household: _____

Social Security Number: _____

Ethnic Origin: _____

Date of Birth: _____
MONTH, DAY, YEAR

Age: _____ Sex: _____

Marital Status: _____

Household Income: _____

Type of Income: _____

Allergies: None Codeine Aspirin Penicillin Sulfa

Other: _____

Do you have any private insurance that covers any part of your prescriptions? Yes No

Do you receive MediCare benefits? Yes No

Do these benefits include prescription coverage? Yes No

Do you receive Medicaid benefits? Yes No

Do these benefits include prescription coverage? Yes No

Do you currently use any other prescription assistance program? Yes No

3. Fill in information about your medications:

Medications Prescribed: _____

Physician: _____

Medications Prescribed: _____

Physician: _____

Medications Prescribed: _____

Physician: _____

Medications Prescribed: _____

Physician: _____

Medications Prescribed: _____

Physician: _____

Medications Prescribed: _____

Physician: _____

Medications Prescribed: _____

Physician: _____

I understand that numerous pharmaceutical companies offer programs that allow qualified persons to receive prescriptions at little to no cost. I, _____, authorize the Prescription ACCESS Program (ACCESS) to act on my behalf in applying for these prescription programs.

In accordance with the new HIPPA and Federal Regulations, I authorize ACCESS to request and/or release all pertinent information regarding my prescription usage and medical history.

YOUR SIGNATURE

DATE

If you need further assistance, please call the ACCESS office at (830) 606-9500.

**MAIL TO: McKenna Prescription Access
801 West San Antonio Street, New Braunfels, TX 78130**