



APPLICATION

By signing this application:

- ◆ I declare that I am an Oregon resident.
- ◆ I declare that I do not have prescription drug coverage (other than Medicare Part D, if applicable).
- ◆ I understand that I may have to give documents to prove what I have said.
- ◆ I agree to cooperate with the Oregon Prescription Drug Program or their designated Pharmacy Benefit Administrator if my case is chosen for review.
- ◆ I understand that giving false or incomplete information may delay or stop my eligibility so that I cannot use the discount drug card.
- ◆ I agree that the Oregon Prescription Drug Program or their designated Pharmacy Benefit Administrator may make payments to pharmacies and take other action related to my discount card.

Declaration and affirmation: I declare that the information given by me is true, correct and complete to the best of my knowledge and belief. I understand that making false statements or withholding information may subject me to penalties as provided in state law.

ALL INFORMATION BELOW MUST BE FILLED OUT TO RECEIVE AN I.D. CARD.

Printed name of Applicant

Date of Birth of Applicant

Street Address (to mail ID card)

(_____)_____
Phone Number

City, State, Zip Code (to mail ID card)

Male (____) Female (____)

X_____
Signature of eligible applicant, or Authorized Representative

Date

Printed name of Authorized Representative
(if applicable)

Where did you hear about this program? (Check as many as apply)

- Newspaper Radio Television OPDP website School or college
 Social Services or Faith-based organizations Other

Each applicant must fill out an application. Mail applications to:

**Oregon Prescription Drug Program
c/o The ODS Companies
Attn: Billing & Eligibility
601 SW 2nd Ave.
Portland, OR 97204-9747**



ASSISTANCE WITH FORM

If you need help filling out this application, or if you do not read English, or if you have vision impairment, and need an alternate format that will meet your needs please call 1-800-913-4146.

Authorized Representative – An authorized representative can sign the application, use the card for the member at the pharmacy, and can call and check on the status of the application.

Answers to Frequently Asked Questions

- ◆ There is no cost to join the program.
- ◆ Each person must fill out an Application.
- ◆ A parent must sign as “Authorized Representative” for a dependent child under 18 years of age.
- ◆ A guardian/personal representative/attorney-in-fact may sign as “Authorized Representative” for an enrollee in their charge.
- ◆ You should receive your I.D. card within 1 week after your application is received.
- ◆ Take your I.D. card to one of the pharmacies listed on the brochure enclosed with your I.D. card (or view the pharmacy list on our website at www.OPDP.org). You will receive a percentage discount depending on the drug. The greatest discount will be on generic drugs.
- ◆ Enrolling in Medicare Part D will not disqualify you from enrolling in this program.
- ◆ If you have Medicare Part D coverage, you may use your OPDP card during the times you pay 100% out of your pocket, which is during the deductible and the “donut hole”. Keep your receipts and mail them into the Part D Plan you signed up with so they can be applied toward your out-of-pocket expenses.
- ◆ Please view our Frequently Asked Question (FAQ) document on our website for more answers to your questions at www.OPDP.org.
- ◆ For more information on applying for an OPDP card, please call 1-800-913-4146.