|  |  |
| --- | --- |
|  |  |
| BlueMail Enrollment Form |
| **BlueMail only ships pills. Patients using other contraceptive methods are not eligible for BlueMail.** |
| First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Middle Initial: \_\_\_\_\_ | Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Phone #: (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_ |
| Shipping Information | **BlueMail can only ship to NH and ME. Patients with a shipping address in a different state than their prescribing health center are not eligible for BlueMail.**  |
|  | Street Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Apt #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | State: \_\_\_\_\_\_\_\_\_ | Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Credit/Debit Card Information |  | [ ] I wish to make a contribution of $\_\_\_\_\_\_\_\_\_\_\_ at each shipment. \*\*A suggested contribution of $5.00 per shipment is greatly appreciated to cover the cost of your shipment. Thank you. |
|  | Card Type: [ ]  Visa [ ]  MasterCard [ ]  Discover |
|  | Card #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Expiration Date: \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ |
| **PPNNE requires all BlueMail enrollees who do not receive fully discounted rate, including those with pharmaceutical insurance, to provide a valid credit/debit card for the cost of your contraception. This includes copays, remaining balances after insurance payments, or remaining balances after any PPNNE discounts. Credit/Debit cards that are invalid, expired, or declined may result in your BlueMail shipments being cancelled or placed on hold. BlueMail does not charge for shipping or handling.** |
| I authorize PPNNE to automatically bill my credit/debit card monthly/quarterly until my prescription expires or until this agreement is otherwise terminated. |
| Cardholder Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ |
| Terms and ConditionsBlueMail will ship the maximum cycles of birth control possible. This is dependent on insurance and inventory. Due to some insurance guidelines we may only be able to send 3 packs of birth control every 10 weeks (8 weeks for patients on a continuous cycle) or 1 pack every 4 weeks (3 weeks for patients on a continuous cycle) until your prescription expires. A note will be included in your final shipment reminding you that it is time to schedule your annual appointment at your health center. At your appointment you may re-enroll in BlueMail.BlueMail requires patients who have pharmaceutical insurance to provide signature on delivery for each shipment they receive to consent to billing their insurance. Failure to provide this can result in the patient being held financially responsible for their shipment and cancellation of their BlueMail subscription. Invalid insurance or loss of coverage may result in your BlueMail shipment being placed on hold or cancelled.Any patient who has applied for New Hampshire Family Planning Program or the MaineCare Limited Family Planning Benefit and is not fully enrolled by the time of their BlueMail shipment will be processed as Self-Pay. This can result in BlueMail charging their credit/debit card for their contraception after any PPNNE discounts have been applied. BlueMail can only ship to addresses within New Hampshire and Maine. Any shipping address outside of our shipping area is not eligible for BlueMail and may result in your shipment being placed on hold or cancelled. Due to pharmaceutical dispensing regulations Patients with a shipping address in a different state than their prescribing health center are not eligible for BlueMail.Allow for 7 business days for the BlueMail Department to process cancellation requests, address changes, and reinstatements. Failure to notify BlueMail of any changes may result in late shipments and/or denial of refund requests for late cancellation requests or for shipments sent to incorrect addresses. |
| I DO want to enroll in the BlueMail program. The information listed above is correct. I understand that it is my responsibility to notify PPNNE if there are any changes to this information or if I wish to stop using the BlueMail program. I will allow for 7 business days for any changes or cancellations to take effect. I understand that BlueMail will stop sending supplies when this prescription expires or all refills have been dispensed and it is my responsibility to schedule any further appointments to renew my prescription as indicated by PPNNE. |
| Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ |
| Office Use Only | Financial Type: [ ]  RX [ ]  MX [ ]  NHFP [ ]  MaineCare LFPB [ ]  SP LV \_\_\_\_\_\_\_\_\_\_\_\_ |
| MR #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health Center: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HCA to scan to 0 – BlueMailScans then shred this form |