Free Prescription Drugs

Available Nationwide for All Ages to Households with Incomes as High as $80,000

To Learn More, Apply or Request a FREE Brochure

Visit: www.FreeMedicine.com *or call* **1-573-996-3333**

Free Prescription Drugs

Free Medicine Enrollment Form

Complete this form & mail along with your processing fee of $5.00 for EACH medication to:

✉ **Free Medicine Foundation • P.O. Box 125, Doniphan, Mo. Postal Code 63935-0125**

Phone: 1-573-996-3333 • Internet: www.FreeMedicine.com

FREE MEDICINE Foundation.com

An Answer to Prayer When You Can't Afford Your Medicine

Most medications are available through free programs. Apply for as many medicines as you need, there is no limit. Free Medicine Foundation offers a money back guarantee.

> *"If it wasn't for this program my nephew would not be here right now, this program saved his life and I would like to thank you for all that you do. He received help from you in the past when he couldn't afford his medicine. Thanks to your help, I am slowly crawling out from under my prescription medicine credit card debt." Cynthia H., Dallas, Texas*

Be sure to include the following items:

1. The name, address and phone number of the person taking the medication(s) and list all of your medication(s).
2. The name and address of the doctor who prescribes the medication(s).
3. Send a refundable $5.00 (one-time processing fee) for **EACH** medication requested to Free Medicine Foundation. It is payable by cash, money order or check to "Free Medicine Foundation" and mail with this completed form.

Please Print Clearly

First Name | M.I. | Last Name

Address (Street number / street name / apartment number / P.O. Box number)

Address Continued (Street number / street name / apartment number / P.O. Box number)

City | State | Postal Code | Today's Date

Phone number | Date of Birth | M ☐ F ☐ Gender | $ _____ Total monthly household gross income

Email Address _____@_____

Are You Diabetic? ☐ Yes ☐ No

Are you on Medicare? ☐ Yes ☐ No

How did you hear about us? _____

Visit www.FreeMedicine.com For Details On How You Can SAVE up to 95% On Your Prescription Medicine NOW!

	NAME OF MEDICATION	STRENGTH	DOSAGE	Times Per Day	DOCTOR'S NAME & ADDRESS
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					

Please Make Copies of This Form if More Medicines Are Needed.

Available in Spanish Online at www. FreeMedicine.com

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Money Back Guarantee Policy: If you are determined ineligible by all applicable sponsors, and receive no medicine assistance, send a written request to Free Medicine Foundation. Include denial letters for all applicable medications within 4 months of original application and your processing fee will be fully refunded.

Total number of medications requested ☐ x $5 EACH = Amount due $_____

Must Include Processing Fee with this Application, it can not be processed without the correct fee enclosed.