Join HealthMapRx™ Today!

Need to manage your diabetes or pre-diabetes, earn incentives, and reduce your out-of-pocket medical costs?

What is HealthMapRx™?

- A **benefit** available to City of Hendersonville employees, retirees and dependents who are currently covered under the health insurance plan.
- A **voluntary program** sponsored by the North Carolina League of Municipalities, in partnership with the City of Hendersonville, and available at **NO COST** to health insurance plan members.
- The North Carolina League of Municipalities and the City of Hendersonville **WILL NOT** have access to the personal health information of program participants.

Do *YOU* qualify?

- Do you take medication for chronic conditions such as diabetes or pre-diabetes?
  If you answered **YES**, you qualify!

What is in it for *YOU*?

- **Participation Incentive:** Each compliant participant will be awarded up to **$120 per year**.
- **Co-pays are covered at 100%** for condition-related preferred medications from the OptumRx Preventative Medication List.
- **Pharmacist Care Manager** will meet with you face-to-face, 4-6 times per year, during work hours.

How do *YOU* enroll? **Four options are available:**

1) **Enroll Online:** https://www.ppcn.org/nclm.html
2) **Contact Suzanne Brown, PPCN Administrative Assistant, Program Support**
   Phone: (336) 580-0340
   Fax: (877) 828-2467
   Email: suzanne.brown@emailmm.com
3) **Contact Lu Ann Welter, Human Resources Coordinator**
   Phone: (828) 233-3204
   Email: lwelter@hvlnc.gov
4) **Complete HealthMapRx™ Participant Information Form (reverse side) and fax or mail to PPCN**

HealthMapRx™ Participant Information Form

Program Participation:

☐ **Diabetes** ☐ **Pre-diabetes (prescribed medication)**

First Name: ____________________ Last Name: ____________________ Middle Initial:_______

Street Address: ____

City: ________________________ State: ______ Zip code: _______ Date of Birth: _________

Email Address: ____

Business Phone: ____________________________ Home Phone: _______________________

Mobile Phone: ______________________________ Gender: ☐ Female ☐ Male

Health Plan Benefits Subscriber's Employer: ____

Medical Insurance ID #: ____

Subscriber Name: _____________________________________Subscriber Date of Birth:________

Preferred Method of Contact:

❒ Mobile (Message) ❒ Mobile (Text) ❒ Email ❒ Home (Message)

❒ Home (No Message) ❒ Business (Message) ❒ Business (No Message)

Ethnicity: (leave blank if preferred)

❒ African American ❒ Asian ❒ Caucasian ❒ Hispanic
❒ Native America ❒ Pacific Islander ❒ Other

Relationship to Employee: ☐ Self ☐ Spouse ☐ Child ☐ Other Retiree: ☐ Yes ☐ No

Emergency Contact: _________________ Relationship:____________ Phone #: ____________

Primary Care Provider: ______________________ Practice Name: ________________________

Please list your providers (ex. Endocrinologist, Cardiologist, Psychiatrist, Kidney Specialist, Therapist, etc.)

Practice Name	Provider Name	Specialty

To enroll, complete and fax: (877) 828-2467 or **mail**: PPCN, 802 Green Valley Rd., Ste. 106, Greensboro, NC 27408