ROWAN COUNTY
NORTH CAROLINA
Be an original.

Join HealthMapRx™ Today!

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

What is HealthMapRx™?

- A **benefit** available to Rowan County employees, retirees and covered dependents who are currently covered under the health insurance plan.
- A **voluntary program** sponsored by Rowan County and available at **NO COST** to participants.
- Rowan County **WILL NOT** have access to any personal health information.

Do *YOU* qualify?

- Do you take medication for diabetes or prediabetes? If you answered **YES**, you qualify!

What's in it for *YOU*?

- **HealthMapRx™ Participation Incentive:** Each compliant participant will be awarded up to **$120 per year**.
- **Diabetes Medication Copays Covered at 100%:**
  - Generic medications
  - Preferred brand injectable medications
- **Diabetes Supplies Copays Covered at 100%:**
  - Preferred brand testing supplies: Continuous Glucose Monitors, strips, lancets
  - Preferred brand administration supplies: syringes, pen needles
- A **Pharmacist Care Manager** will meet with you face-to-face 4-6 times per year, typically during work hours.

How do *YOU* enroll?

Four options are available:

1) **Enroll Online: https://www.ppcn.org/RowanCounty.html**
2) **Complete the HealthMapRx™ Participant Information Form on reverse side, then fax or mail to PPCN**
3) **Contact Suzanne Brown, PPCN Administrative Assistant, Program Support**
   Phone: (336) 580-0340
   Fax: (877) 828-2467
   Email: suzanne.brown@emailmm.com
4) **Contact Aldrea Speight, Human Resources Analyst, Rowan County**
   Phone: (704) 216-8163
   Email: aldrea.speight@rowancountync.gov

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

Occupation: _____

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