Compassionate Care Program

Compassionate Care

PATIENT ENROLLMENT FORM

Phone: (855) 541-5926 Fax: (919) 415-2870

PATIENT INFORMATION	Please remember that your program eligibility requires that you promptly notify the Compassionate Care Program by calling (855) 541-5926 if you become insured by any private or government insurance plan	
FIRST NAME	LAST NAME	MI
DATE OF BIRTH	GENDER ☐ Male ☐ Female	By providing your e-mail address, you consent to receive additional mailings from the Compassionate Care Program. E-MAIL
HOME PHONE	MOBILE PHONE	
MAILING ADDRESS	CITY / STATE / ZIP CODE	
PREFERRED METHOD OF CONTACT ☐ Home phone ☐ Mobile phone ☐ Mail ☐ E-mail	COUNTRY	

Please indicate if you or your partner are active, veteran or retired US Military: ☐ Yes (Indicate branch):_____ ☐ No

Please indicate your dates of service. From _____ Until_____ (Month/Day/Year)

FAX OR MAIL YOUR INCOME VERIFICATION FORM TO:

Fax: (919) 415-2870 Mail: The Compassionate Care Program • 2250 Perimeter Park Drive, Suite 300 • Morrisville, NC 27560

We will need to know the annual adjusted income for the entire household. The following are acceptable income documents that we can use to validate your income:

- ☐ 1040 Form
- ☐ 1040A Form
- ☐ 1040EZ Form
- ☐ 1040 Form Married Filing Separately (MFS) (Need a form from both filers)
- ☐ 1040A Form (MFS)
- ☐ 1099 Form

How many people live in your household?

PATIENT SIGNATURE AND AUTHORIZATION:

Fax: (919) 415-2870 Mail: Compassionate Care Program • 2250 Perimeter Park Drive, Suite 300 • Morrisville, NC 27560

My signature below certifies that I have completed all of the above sections completely, accurately, and to the best of my knowledge and that I have read, understand, and agree to the terms of this enrollment form and the attached Authorization to Use and Disclose Health and Other Personal Information form. If I am an active duty or retired military member, I commit to making the Compassionate Care Program aware, if at any time, I gain private insurance coverage for infertility treatment. If I am not an active duty or retired military member, I commit to making the Compassionate Care Program aware, if at any time, I gain any insurance coverage for infertility treatment. No units of product received under this program or any medical expenses related to my fertility treatment will be submitted for Medicare, Medicaid, TRICARE, the Department of Veterans Affairs, the Department of Defense, or any public or private third-party reimbursement, or returned for credit.

Please remember that, as discussed above, your program eligibility requires that you promptly notify the Compassionate Care Program by calling (855) 541-5926 if you become insured by any private or government insurance plan.

PATIENT SIGNATURE	PATIENT NAME	DATE

ART CENTER CONTACT OR SITE NAME:

If applicable, please provide an e-mail address for the person who manages the Compassionate Care Program at your ART Center.

ART CENTER	CONTACT E-MAIL CompassionateCare@MandellsRx.com

For assistance or additional information, call (855) 541-5926 Monday to Friday, 8:00 AM to 8:00 PM EST

Authorization to Use and Disclose Health and Other Personal Information

Patient's Name _____

Address _____

Home Phone _____ DOB ____/____/_____

I authorize my physician and his/her staff to disclose my health and other personal information, including, but not limited to, the information on this form, to EMD Serono, Inc. and its agents and representatives including any company that helps administer EMD Serono's Compassionate Care Program (collectively "EMD Serono") so that EMD Serono may use and further disclose my information to healthcare providers, pharmacies, insurance companies, prescription drug plans and other third-party payers (collectively, "Third Parties") in order to:

(1) contact me by mail, e-mail, and/or telephone to enroll me in, and administer EMD Serono's Compassionate Care Program;

(2) provide me with materials relating to EMD Serono's Compassionate Care Program;

(3) verify the accuracy of the information I provide and in my application for EMD Serono's Compassionate Care Program;

(4) conduct surveys to measure my satisfaction with EMD Serono's Compassionate Care Program.

I further authorize the Third Parties to disclose health and other personal information about me in their possession to EMD Serono in order to assist EMD Serono in accomplishing the purposes described above.

I understand that once my information is disclosed pursuant to this authorization, there is no guarantee that it will not be disclosed to another third party. However, I understand that EMD Serono will not release my information to any party, except as provided in this authorization or as permitted by applicable law, without first obtaining my (or my authorized representative's) separate written consent.

I understand that I may refuse to sign this authorization and such refusal will not affect my ability to receive EMD Serono Products, but it will limit my ability to participate in EMD Serono's Compassionate Care Program.

I understand that this authorization will remain in effect for ten years from the date of my signature, unless I revoke it earlier by contacting EMD Serono or its representatives in writing by mail or fax at 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560, fax (919) 415-2870. If I revoke this authorization, EMD Serono will stop using and disclosing my information as soon as possible, but the revocation will not affect prior use or disclosure of my information in reliance on this authorization.

I understand that the services provided by EMD Serono that are described in this authorization can be changed at any time, without prior notification.

I also understand that I have the right to receive a copy of this authorization.

Patient name (please print): _____

Signature of patient (or personal representative): _____ Date ____/____/_____

Authority/relationship of personal representative (if applicable): _____

Signature of patient (or personal representative): _____ Date ____/____/_____

Authority/relationship of personal representative (if applicable): _____

PATIENT MUST SIGN THIS FORM THEN SEND OR FAX BOTH PAGES