

Patient Assistance Program

Section 1 - Physician and Prescription Information

Physician Name		DEA/State License #:	Phone: ()	
			Alt. Phone: ()	
			Fax: ()	
Address: (no P.O. Box)		City:	State:	Zip:

Diagnosis (ICD9 Code):

Prescription

Drug Name & Strength:	Quantity:

Physician/Prescriber Attestation: To the best of my knowledge, this patient has no medical insurance (including Medicaid or other public programs) for this prescription. I verify that the information provided is complete and accurate to the best of my knowledge. I understand that the medication prescribed above shall be sent to my office for dispensing to this patient, and I certify that the medication requested above shall only be used to treat this patient and I shall not seek reimbursement for this medication from any third party

Physician Signature:	Date:

Section 2 - Patient Information

Patient Name:		SS#:	
		- -	
Street Address:		Date of Birth:	Male <input type="checkbox"/>
		/ /	Female <input type="checkbox"/>
City	State	Zip	Phone ()
Number of Household members (including self)? (circle one) 1 2 3 4 5 6 7 other	U.S. Citizen? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you a Veteran of the US Armed Forces? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you Disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>
Did you file a U.S. State and/or Federal Income Tax return last year? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, why not?			

Financial Information Note: You must attach copy of your most recent Federal Income Tax Return, i.e., IRS Form 1040, 1040A, 1040EZ, 1040NR

List All Sources, Gross Monthly Amounts

Salary/Wages \$ _____	Social Security \$ _____	Child Support/Alimony \$ _____
Social Security Disability \$ _____	Pension/Retirement \$ _____	Unemployment/Work Comp \$ _____

Total Gross Household Monthly Income: \$ _____

Insurance Information	Check one	Policy Number	Phone Number
Private Drug Coverage	<input type="checkbox"/> Yes <input type="checkbox"/> No		()
Medicaid	<input type="checkbox"/> Yes <input type="checkbox"/> No		()
Medicare	<input type="checkbox"/> Yes <input type="checkbox"/> No		()
Medicare Part D	<input type="checkbox"/> Yes <input type="checkbox"/> No		()
State Elderly Drug Assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No		()
Aids Drug Assistance Program	<input type="checkbox"/> Yes <input type="checkbox"/> No		()

I certify that this information is complete and accurate to the best of my knowledge, and that I am unable to afford the medication requested. I understand that additional information may be requested to process this application, but that all medical and financial information will be kept confidential, except as otherwise required by law. I understand that the Product(s) made available to me under this program may be denied to me if I do not fully cooperate with efforts made to verify the information provided in this Application, or if I do not take steps to secure alternative means of prescription coverage that are available to me, after I become aware of such alternatives. I certify that I shall not seek reimbursement for any medication dispensed as part of this program.

I hereby authorize the program to obtain and disclose information from physicians, insurance companies and other information as necessary to verify the information provided in this application. Boehringer Ingelheim Cares Foundation, Inc. is not responsible for verifying any of the information contained in Section 1 above or other medications that I am taking.

Patient's Signature:	Date: