PAN Foundation

P.O. Box 30500, Bethesda, MD 20824 Fax: 1-866-316-7261 www.panfoundation.org

Dear

Thank you for requesting an application to receive assistance from the Patient Access Network (PAN) Foundation. The PAN Foundation is an independent, national 501 (c)(3) organization dedicated to helping federally and commercially insured people living with life-threatening, chronic and rare diseases with the out-of-pocket costs for their prescribed medications. Assistance is provided in the form of reimbursement for out-of-pocket medication expenses covered by your insurance carrier and used to treat your illness. These expenses are subject to a benefit limit and eligibility is based on pre-established criteria. Enclosed is the requested application.

Completed applications can be mailed or faxed to the PAN Foundation:

Patient Access Network Foundation
P.O. Box 30500
Bethesda, MD 20824

Fax: 1-866-316-7261

We recommend keeping a copy of your application for your records. The PAN Foundation is not responsible for misplaced or lost documents.

Once we receive your application, we will notify you within two business days regarding the status of your application and any additional information that is required to process your application. If you have any questions about the application or application process, please contact the PAN Foundation toll free at **1-866-316-7263**, **Monday through Friday, 9 a.m. to 7 p.m. ET.**

Sincerely,

PAN Foundation

Enrollment Application
Patient Information

Patient Name:
Patient Social Security Number:

To apply for assistance from the Patient Access Network (PAN) Foundation, please complete each section to the fullest extent possible. In Section 2, be sure to note that you are applying to the Fund. If an item does not apply to your situation, please note "N/A" on that line. If you have any questions about this application or the application process, please call the PAN Foundation at 1-866-316-7263.

Please be aware that completing an application does not guarantee the availability of assistance. The PAN Foundation provides assistance based on eligibility criteria, availability of funding and the terms and conditions that the PAN Foundation establishes for awarding assistance. The PAN Foundation may provide either full or partial financial support, based on Foundation policies and availability of funding.

All fields with an asterisk (*) are required

Section 1 – Eligibility Pre-Screen

Please provide responses to the following questions, which will be used to assess the patient's eligibility to receive assistance:

*Is the patient living and receiving treatment in the U.S. or U.S. territories? ❑ Yes ❑ No

*Does the patient have health insurance coverage? ❑ Yes ❑ No If Yes: ❑ Commercial (Employer Sponsored) ❑ Commercial (Private or Exchange/Marketplace) ❑ Medicare (original fee-for-service, parts A, B, or D) ❑ Medicare Advantage ❑ Medicaid (Medicaid, Medicaid HMO, MediCal, or CHIP) ❑ TRICARE ❑ OTHER

Section 2 – Patient Information

*Patient Name:		
*DOB:	*Gender: ❑ Male ❑ Female	
*Email Address:		
*Street Address:		
*City:	*State:	*ZIP Code:
*Telephone:	Alternate Telephone:	
Authorized Contact:		
Relationship:	Contact Telephone:	
Authorized Contact Email Address:		
*Disease Fund:		
*Name of Medication(s):		

Section 3 – Insurance Carriers

List all insurance carriers, including Medicare, Medicaid and any other health plan or programs that provide coverage for your medical expenses and provide copies of both the front and back of your medical and prescription drug insurance card(s).

*Primary Insurance Carrier:	Telephone:
*Policy ID Number (Including any letters):	Group Number:
Secondary Insurance Carrier:	Telephone:
Policy ID Number (Including any letters):	Group Number:
Tertiary Insurance Carrier:	Telephone:
Policy ID Number (Including any letters):	Group Number:

Please return this completed form and required documentation to:
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Section 4 – Financial Information

*How many people reside in the patient's residence? (Example: You, your spouse, and two children = 4)
*What is the patient's annual adjusted gross income? $

Section 5 – Provider Information

*Provider Name:		National Provider Identifier (NPI):
*Street Address:		
*City:	*State:	*ZIP Code:
*Telephone:	*Email:	

Section 6 – Applicant Declaration

I, the named Applicant, attest and certify, under penalty of law to the Patient Access Network (PAN) Foundation and the agents lawfully acting on its behalf, that the information provided in my application is complete and accurate. I understand that reported financial information may be verified by an audit, as deemed necessary by the PAN Foundation. I further understand that any false or incomplete information provided by me in this application could unduly harm the PAN Foundation, its reputation and its tax exemption status and, therefore, may also constitute fraud for which I may be legally liable. I also understand that, if I am approved for assistance by the PAN Foundation, assistance will terminate and the PAN Foundation may recoup the amount of any financial assistance provided to me if the PAN Foundation becomes aware of any inaccurate information or fraudulent activity relating to my application or the assistance provided to me by the PAN Foundation. Finally, I understand that I am not guaranteed or promised assistance, and that any assistance the PAN Foundation may provide is limited to the terms and conditions established by the PAN Foundation and that the PAN Foundation reserves the right at any time and for any reason, without notice, to: (i) modify this application form, (ii) modify or discontinue any assistance provided by the PAN Foundation or the PAN Foundation's eligibility criteria or (iii) terminate assistance.

I agree with all declarations presented above and confirm that I understand that submitting this application is a legally binding agreement to my understanding of the attestations.

***Patient Name (please print)**:	
***Patient Signature**:	***Date**:
Parent / Guardian / Representative:	**Date**:

Please return this completed form and required documentation to:
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Fax: 1-866-316-7261

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Enrollment Application
Patient Information

Patient Name:
Patient Social Security Number:

Authorization to Release Medical and Insurance Information

*__Patient Name__:

*__Patient Social Security Number__:

In order for the undersigned applicant to receive assistance through the Patient Access Network Foundation, I authorize my healthcare provider(s) and my insurance company(ies) to disclose to the Patient Access Network Foundation and its employees, third-party administrators, agents and other representatives (collectively "the Foundation"), information about me, my current medical condition and my health insurance coverage. This information can include spoken or written facts about me from my healthcare provider(s) and my insurance company(ies) about my health or healthcare.

I understand that if I do not sign this authorization, I will not be eligible to receive assistance through the Foundation. I may revoke this authorization at any time by mailing or faxing a signed letter of revocation to the Foundation at the address listed below, but if I revoke this authorization, I will not be able to receive assistance through the Foundation. If I tell my healthcare provider(s) and my insurance company(ies) in writing that I do not want them to share information about me with the Foundation, the Foundation will not provide assistance to me.

I understand that the Foundation will use and disclose the information it receives about me to see if I qualify for assistance and that the Foundation also may use and disclose my information to refer me to, or to determine my eligibility for, other programs, foundations or alternate sources of funding or coverage that may be available to provide assistance to me with the costs of healthcare products and services. I also understand that the Foundation may use and disclose my information for its own operational needs in managing patient assistance programs. I understand that the Foundation will make every effort to keep my information private, but if it is accidentally disclosed to persons who should not receive it, federal privacy laws may no longer protect my information.

This authorization expires either one year after the date it is signed, or when I am no longer participating in a Foundation patient assistance program. I understand that I am entitled to keep a copy of this authorization.

*__Patient Name (please print)__:

*__Patient Signature__:	*__Date__:
Parent / Guardian / Representative:	**Date**:

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