Abbott Patient Assistance Foundation's Diabetes Care Patient Assistance Application

The Abbott Patient Assistance Foundation provides Abbott diabetes care products at no cost to patients experiencing financial difficulties. Eligible patients typically have no healthcare coverage for the requested product and do not have access to alternative sources of coverage or funding. All applications are reviewed on a case-by-case basis to support the Abbott Patient Assistance Foundation's purpose of providing products at no cost to individuals in need.

Checklist for submitting an application:

- ☐ Ensure all sections of the application are completed. Incomplete applications will be returned for proper completion and resubmission.
- ☐ Documentation of monthly income (e.g. Federal tax return, W2, full month of pay stubs). If no income, please submit a signed and dated letter, indicating there is no income.
- ☐ Copy of Medicaid Denial Letter dated within 2 years, if applicable.
- ☐ Copy of Prescriber's order indicating your daily testing frequency required if not included on the application.
- ☐ Patient's signature/date is required at the bottom of the application.
- ☐ Physician's signature/date is required on the application.

Fax or mail the completed application and documentation to:

Abbott Patient Assistance Foundation-Diabetes Care
PO Box 270
Somerville, NJ 08876
Fax: 1-866-898-1473
Phone: 1-800-222-6885

Upon receipt of a completed application, the patient will be notified of program eligibility. If eligible, a supply of product will be shipped to the patient's home. It is the responsibility of the prescriber or patient to reorder 3 weeks prior to the patient requiring further medication.

Please contact us at 1-800-222-6885 Mon-Fri 8am-5pm CST for additional assistance.

Abbott
Patient Assistance
Foundation

Diabetes Care Patient Assistance Program Application

Abbott Patient Assistance Foundation
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Phone:1-800-222-6885 • FAX: 1-866-898-1473

Applications are available by calling 1-800-222-6885 or visiting www.abbottpatientassistancefoundation.org

Part I: INFORMATION FROM PRESCRIBER

A. PRESCRIBER INFORMATION

☐ Please check box to indicate change of address.

State License #:	Expiration Date:		DEA#:
First Name:	M.I.:	Last Name:	
Professional Designation:		Primary Specialty:	
Office Shipping Address:		City:	State: ZIP:
Office Mailing Address:		City:	State: ZIP:
Office Contact and Title:	Phone:		Fax:

B. GLUCOSE METER CURRENTLY USED (If meter currently used differs from brands supported by program, a new meter will be provided. Preferred product available is Freestyle.)

Does patient have a glucometer? ☐ Yes ☐ No **If yes, check One:** ☐ FreeStyle ☐ FreeStyle Lite ☐ Precision	Testing Frequency: _____	Ship to: ☐ Patient ☐ Physician	Reorders Allowed: Up to 1 year

C. CERTIFICATIONS

Note: Prescriber may not delegate signature authority. (STAMPS NOT ACCEPTED)

1. Authorization for Release of Health Information: By signing this form, I represent to the Abbott Patient Assistance Foundation that I have obtained all necessary Federal and State authorizations and consents from my patient to allow me to release health information to the Abbott Patient Assistance Foundation and its contracted third parties.
2. Physician/Care Coordinator Verification: I verify that the information provided is current, complete and accurate to the best of my knowledge. If this applicant is eligible for the Abbott Patient Assistance Foundation's Diabetes Care Patient Assistance Program (PAP), I understand that the product will be sent to the applicant's home. The Foundation reserves the right to request additional information if needed and to change or discontinue this program at any time, without notice.

By signing this form, I certify that the applicant is under my ongoing supervision for their medical condition and that I am recommending the aforementioned product for the applicant. I acknowledge that I shall not seek reimbursement for any product provided hereunder from any government program or third-party insurer. I also understand that the applicant's acceptance by the Abbott Patient Assistance Foundation is not made in exchange for any explicit or implicit agreement or understanding that Abbott Product will be used, purchased, leased, ordered, prescribed, recommended, or arranged for or provided formulary or other preferential or qualifying status. I understand that I may not delegate signature authority. I certify that treatment with this product is medically necessary.

Prescriber's Signature: _____ Date: _____

Part II: PATIENT INFORMATION

A. PATIENT INFORMATION

☐ Please check box to indicate change of address

Social Security #:	First Name:	M.I.	Last Name:	
Address: (No PO Box):		City:	State:	Zip:
Phone:	Gender: ☐ M ☐ F	Date of Birth:		

B. FINANCIAL INFORMATION — DO NOT SEND ORIGINALS

Attach the most current copies of income documents for you and all dependent persons in the household. *Acceptable documents include Federal tax return, SSA-1099, W2, pay stubs or benefits award letter.*

Monthly income for all in household:	Salary/Wages	$ _____	Disability	$ _____	Circle # of people in household including yourself 1 2 3 4 5
	Social Security	$ _____	Other	$ _____	

C. PRESCRIPTION COVERAGE INFORMATION

Private Drug Coverage Insurance	Medicare			Medicaid		Other State/Government	
☐ Yes ☐ No	☐ Yes, If yes, list total assets, not including home, vehicles, or burial plot $_____		☐ No	☐ Yes	☐ No	☐ Yes	☐ No
	☐ Medicare Part A	☐ Medicare Part B	☐ Medicare Part D (name): _____	Circle # in household under 18 years old. 0 1 more		If, yes, please indicate type:	

D. REPRESENTATIVE FOR PURPOSES OF PROGRAM

I permit the Abbott Patient Assistance Foundation to speak with the following person(s) about my application and/or care and sign any documents related to the Program on my behalf:

Name:_____ Relationship: _____ Phone #: _____

E. CERTIFICATION

I understand that any assistance in the form of product at no cost is contingent upon my ability to meet the eligibility criteria for the Abbott Patient Assistance Foundation. In the event that I am eligible for Foundation assistance, I acknowledge that this assistance is temporary and that I may be asked to reapply at designated intervals by the Foundation. I also understand that the Foundation assistance may change or be discontinued at any time without any notice to me. I agree that I will not seek reimbursement for any products dispensed under the Foundation from any government program or third party insurer. I certify that the information I have provided in this form is accurate and complete. I understand that by completing this form I am not guaranteed eligibility to receive medication from the Foundation. I agree that I will notify the Foundation if my insurance or financial situation changes.

Patient's Name (printed): _____ Patient's Signature: _____ Date: _____

Personal Representative Authorization (if Applicable):

Note: If the Applicant is unable to sign, is under the age of 18, or has designated signature authority, the Applicant's Personal Representative may sign this Form. However, only certain individuals may qualify as the Applicant's Personal Representative for purposes of this Authorization. An Applicant's Representative must have the requisite knowledge and information regarding the Applicant's financial and health care status to verify that all responses provided are accurate. State law may prescribe who can be a Personal Representative for purposes of this Authorization. A person or entity in the supply chain of the product to be received through the Foundation, including a health care provider or pharmacy receiving the medicines at no cost, may not be named a Personal Representative. If Applicant's Personal Representative is a consumer assistance or charitable organization, please list name of entity and purpose of entity under Relationship to Applicant.

Patient's Representative Signature: _____ Relationship: _____ Date: _____

Notice to Health Care Providers and Insurers: This form of authorization may not comply with all applicable Federal and State Laws governing disclosure of the applicant's information to the Foundation and its contracted third parties. The Foundation urges all entities disclosing information about the applicant to consult with legal counsel prior to relying on this form.