Abbott Patient Assistance Foundation Application

The Abbott Patient Assistance Foundation provides Abbott medicines 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 further information.

☐ Attach proof of income (tax return, W2, pay stub) for all in household.

☐ Prescriber’s signature/date is required on the application.

☐ Patient’s signature/date is required at the bottom of the application.

☐ Provide a copy of Medicare card or letter of Medicaid and/or Social Security denial, if applicable.

Fax or mail the completed application and documentation to:

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

Upon receipt of a completed application, the prescriber and patient will be notified of program eligibility. A supply of medication will be shipped to the prescriber’s office. It is the responsibility of the prescriber or office staff 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.
Part I: INFORMATION FROM PRESCRIBER

Part II: PATIENT INFORMATION

First Name: M.I. Last Name:____________________

Address: (No PO Box):____________________

City:____________________ State:____________________ ZIP:____________________

Office Contact and Title:____________________ Phone:____________________ Fax:____________________

B. PRODUCT INFORMATION

Product:____________________

Strength:____________________ Sig:____________________ 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 release health information to the Abbott Patient Assistance Foundation and its contracted third parties.

2. Physician/Care Coordinator Verification: I certify that treatment with this medication is medically necessary.

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 Personal Representative may not delegate signature authority. I certify that treatment with this medication is medically necessary.

A. PATIENT INFORMATION

Social Security #:____________________

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

Part A

Yes □ No □

Does the patient have Medicare Part A?

Yes □ No □

If yes, is the Medicare Part A coverage adequate? If no, please indicate type:

Part B

Yes □ No □

Does the patient have Medicare Part B?

Yes □ No □

If yes, is the Medicare Part B coverage adequate? If no, please indicate type:

Part D

Yes □ No □

Does the patient have Medicare Part D coverage?

Yes □ No □

If yes, is the Medicare Part D coverage adequate? If no, 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 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 Personal Representative must have the requisite knowledge and information regarding the Applicant’s financial and health 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 healthcare provider or pharmacy receiving the medicines at no cost, may not be named a Personal Representative. If the Applicant’s Personal Representative is a consumer assistance or charitable organization, please list name of entity and type of entity under Relationship to Applicant.

Personal Representative Signature:____________________ Date:____________________

Relation to Applicant:

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.

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