Roche Diagnostics Corporation ("Roche") Patient Assistance Program

Roche stands committed to assuring access to ACCU-CHEK® blood glucose test strips (the "covered products") for those patients who have medical and economic need. As part of our commitment, the Roche Patient Assistance Foundation is philanthropic and designed as an interim solution for qualifying patients who lack third-party private or public outpatient insurance coverage or other reimbursement and cannot afford to purchase the covered products on their own. The Patient Assistant Program (the "Program") is not intended to supplement or supplant third-party insurance coverage by public or private payers. While Roche will make every effort to make covered products available when needed, the Program is limited by available resources and may be discontinued or changed at any time without notice.

Prior to submitting an application, the patient's medical provider should determine that the patient is an outpatient, ineligible for third-party outpatient insurance coverage or other reimbursement under private insurance, government funded programs (Medicaid, Medicare, VA), or private/community sources, and unable to afford the cost of therapy on their own. The covered products are offered to patients through licensed practitioners with valid DEA and state license numbers. The Program is for individual patients who fall within the Program's pre-established criteria. It is not intended for clinics, hospitals or other institutions.

This application must be completed to enter new patients into the Program. The medical provider's original signature and DEA/State License # is required on all applications. Once the application is received and it is determined the patient qualifies for the Program, delivery may take up to one week. The Program eligibility period is 1 year. Thereafter, reapplication is required. Roche will ship no more than a three months' supply of covered products at a time during the eligibility period. Roche (or its agent) will contact the patient or his/her physician to confirm a delivery date for product.

IMPORTANT: IF YOU HAVE ISSUES OR QUESTIONS REGARDING YOUR ACCU-CHEK® PRODUCT, YOU SHOULD CONTACT THE ACCU-CHEK CUSTOMER CARE SERVICE CENTER AT 1-800-858-8072

Patient:

- ☐ 1. Please complete Section 1
- ☐ 2. Attach copy of requested financial documentation (1040, 1040EZ, SSA 1099 with 4506-T, etc.)
- ☐ 3. Have your physician complete Section 2
- ☐ 4. Obtain a prescription for requested product from your physician
- ☐ 5. Mail completed application (sections 1 and 2), financial documentation and prescription to:

Roche Diagnostics Patient Assistance Program
PO Box 18740
Louisville, KY 40261

6. If you have any questions please call 1-866-441-4090

Physician:

- ☐ 1. Please complete Section 2
- ☐ 2. Have your patient complete Section 1
- ☐ 3. Provide prescription for requested product
- ☐ 4. Have you or your patient mail completed application (sections 1 and 2), financial documentation and prescription to:

Roche Diagnostics Patient Assistance Program
PO Box 18740
Louisville, KY 40261

5. Once your patient is approved for the program, you may re-order their covered products during the one-year eligibility period by faxing a re-order form to 1-866-441-4091. (Note: all enrollment applications must be mailed)
6. If your patient completes therapy or discontinues therapy, please complete the withdrawal form and fax to 1-866-441-4091
7. If you have any questions please call 1-866-441-4090

Section 1 - Patient Information

Patient Name:				
Gender: Male ☐ Female ☐	SSN:	Date of Birth:		
Address:	City:	State:	Zip:	Phone: ( )
Number of Household members (including self)? (Circle one) 1 2 3 4 5 6 7 8	Legal U.S. Citizen? Yes ☐ No ☐	Are you a Veteran of the US Armed Forces? Yes ☐ No ☐		Are you Disabled? Yes ☐ No ☐

Monthly Gross Household Income. List All Sources.

Note – You must attach a copy of your most recent tax returns (1040, 1040A, SSA 1099 w/ 4506-T, etc.)

Salary/Wages $_____ Social Security $_____ Child Support/Alimony $_____

Social Security Disability $_____ Pension/ Retirement $_____ Unemployment/ Work Comp $_____

Total Monthly Gross Household Income: $_____

Total Patient Assets: $_____ (This includes savings/checking, IRA, annuities, stocks/bonds/CDs)

Insurance Information	Check one	Policy Number	Phone Number
Private Insurance	☐Yes ☐No		( )
Medicaid	☐Yes ☐No		( )
Medicare	☐Yes ☐No		( )
Other State Healthcare Coverage (e.g. Universal Coverage)	☐Yes ☐No		( )

Verification and Authorization and Release of Medical Information Statement for Patient Assistance Program ("Program")

I verify that the information provided in this application is complete and accurate to the best of my knowledge and may be used by the Roche Patient Assistance Foundation, Roche Diagnostics Corporation and/or their respective agents, service providers or authorized designees, which may administer the Program (singly or collectively, the "Program Administrator"). I am unable to pay for the covered products on my own, and understand that at such time as I obtain insurance coverage or other reimbursement or have financial resources to pay for their cost that I will notify Roche of such a change in my coverage or financial status. I understand that, by my signature, any and all information that I provide may be shared with my treating medical provider. I authorize my medical provider who is completing this application to share information about me or my medical condition, including diagnosis, treatment, physical examinations, or other information in my medical records. This information can be shared with the Program Administrator. This information can be used and shared to determine whether I am eligible for insurance coverage or other reimbursement for the covered product(s) for which I am applying and eligible for the Program; to administer the Program; and to assess the quality of Program services. I understand that once the Program Administrator receives my information, it may be re-disclosed and no longer protected by federal privacy regulations. The Program Administrator will share information it receives through this application process and from my medical provider with any health insurers I may have. My health insurers may respond by disclosing information about me and my insurance coverage to the Program Administrator. The Program Administrator may share that information with my medical providers. I understand that I do not have to sign this form. If I do not sign it or if I cancel it, I cannot participate in the Program. I am not required to sign this in order to get treatment or benefits from my medical provider or insurer. I can cancel this authorization at any time by notifying my medical provider or health insurer in writing at its respective place of business. This will prohibit my medical provider or insurer from sharing any more information after they receive and process my cancellation. It won't prohibit the Program Administrator from using and disclosing any information it may have already received. This authorization expires two (2) years after I sign it. I am entitled to a copy of this authorization. The Program Administrator will not use or disclose any information obtained for this Program except for the purposes included above or as required by law. I understand and agree to the above Verification and Authorization and Release of Medical Information statement. If questions, call _____.

Patient's Original Signature:	Date:

Please attach a copy of your financial documentations

Section 2- Physician Information

Physician Name	DEA/State License #:	Phone: ( ) Fax: ( )	
Address: (no P.O. Box)	City:	State:	Zip:
Diagnosis (ICD9 Code):			
Please send this supply of covered products to: ☐ Patient Address		☐ Physician Address	

Please attach a prescription for the requested product.

I certify that the information submitted on this application is true and that the covered product(s) received as a result of this application will be used to treat **ONLY** the patient identified above. I will not charge for or sell the covered product(s). I further certify that the use of the covered product(s) identified above is medically necessary and I will be supervising the patient's treatment accordingly. To the best of my knowledge, this patient has no insurance coverage or other reimbursement for the covered product(s).

Physician Original Signature:	Date:

For office use only:
Application Reviewed by *Product* *Department*

IMPORTANT: IF YOU HAVE ANY ISSUES OR QUESTIONS REGARDING YOUR ACCU-CHEK® PRODUCTS,