Abbott Patient Assistance Foundation Medical Nutrition Products Patient Assistance Program Application

The Abbott Patient Assistance Foundation provides Abbott medical nutrition 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. **The Abbott Patient Assistance Foundation's Medical Nutrition Products Patient Assistance Program is designed to supplement medical nutrition product needs.**

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, or benefit awards letter) 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 copy of Medicaid and/or Social Security denial, if applicable.
- ☐ Provide copy of private insurance denial letter OR the published policy that states nutritional products are not a covered benefit, if applicable.

Fax or mail the completed application and documentation to:

Abbott Patient Assistance Foundation
PO Box 270
Somerville, NJ 08876
Fax: 1-866-483-1305
Phone: 1-800-222-6885

Upon receipt of a completed application, the prescriber and patient will be notified of program eligibility. The approved supply of product will be shipped to the patient's home. It is the responsibility of the prescriber's office or the patient to reorder 3 weeks prior to the patient's approved product supply running out.

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

Abbott Patient Assistance Foundation

Medical Nutrition Products Patient Assistance Program Application

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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. PRODUCT INFORMATION

Product (1): _____ Flavor: _____ Administration: ☐Oral ☐Tube Reorders Allowed: Up to 1 year

Estimated Total Caloric Need of Patient (Daily): _____ % Caloric Need to be met with Product:_____ Number per Day:_____ (Cans)

Product (2): _____ Flavor: _____ Administration: ☐Oral ☐Tube Reorders Allowed: Up to 1 year

Estimated Total Caloric Need of Patient (Daily): _____ % Caloric Need to be met with Product:_____ Number per Day:_____ (Cans)

Primary Diagnosis: _____ **Indications for Use:** _____

Please provide both a primary diagnosis (i.e. cancer, HIV/Aids, diabetes, etc.) and the indications for use (i.e. involuntary weight loss, cachexia, malnutrition, etc.) that requires the need for nutritional therapy. *Applications for Metabolic products and EleCare require a primary diagnosis only.*

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 Medical Nutrition Products Patient Assistance Program (PAP), I understand that the nutritional 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 nutritional therapy and that I am recommending the aforementioned nutrition product for the applicant. I acknowledge that I shall not seek reimbursement for any nutrition 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 nutrition 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 copies of income documents that support the current income listed below 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 $_____ Social Security $_____ Other $_____

Circle # of people in household including yourself: 1 2 3 4 5

C. HEALTH BENEFIT INFORMATION

Private 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 product 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 products 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.