ARCH FOUNDATION
PATIENT ASSISTANCE PROGRAM FOR MIRENA®
ARCH Foundation, P.O. Box 220908, Charlotte, NC 28222-0908
Telephone: (877) 393-9071 Fax: (877) 229-1421

Please complete each section to the fullest extent possible. If an item does not apply, please note "N/A" on that line.
Please return this completed confidential application to the above address or fax number.

PROVIDER INFORMATION

Provider Name: _____ MD / NP / Other
Facility Name: _____
Facility NPI: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: (_____) _____
Fax Number: (_____)_____
Contact Person: _____
State License Number: _____
Email Address:_____

Please indicate shipping address if different from above:

Facility Name: _____
Facility NPI:._____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: (_____) _____
Fax Number: (_____)_____
Contact:Person: _____

Please indicate if your clinical setting is (check all that apply):

- ❑ Title X
- ❑ Planned Parenthood
- ❑ Family Planning Clinic
- ❑ Public Health Clinic (State, City, County)
- ❑ Private Group Practice
- ❑ Private Individual Practice
- ❑ Hospital

PROVIDER DECLARATION AND AUTHORIZATION

I verify that the information provided in this application is complete and accurate. I verify that, to the best of my knowledge, this patient does not have Medicaid or any other form of insurance or other means to access Mirena®. I understand that the patient must qualify financially and meet the program criteria to be eligible for assistance. I also understand that the ARCH Foundation reserves the right at any time, and without notice, to modify the application form; to modify or discontinue this program and its eligibility criteria; or to terminate assistance. I also understand that the product I receive is not a sample. My signature below confirms that Mirena® will be provided free of charge to this patient as deemed medically appropriate for family planning purposes. I also verify that, to the best of my knowledge, this patient has no insurance coverage for Mirena®.

_____
Provider Signature Date

PATIENT INFORMATION

Patient Name: _____
Patient Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____
Day Phone: (_____) _____
Evening Phone: (_____) _____

COVERAGE AND INSURANCE

Do you have Medicaid?

❑ YES ❑ NO

Do you have any other form of private or public insurance coverage?

❑ YES ❑ NO

If Yes, please explain why you cannot access Mirena® through that insurance coverage and any steps you have taken to obtain coverage:

_____
_____

FINANCIAL INFORMATION

Current annual household income: $ _____

Number of household members dependent on income stated above (include yourself): _____

APPLICANT DECLARATION AND AUTHORIZATION

I verify that the information provided in this application is complete and accurate. I verify that I do not have Medicaid or any other form of insurance or other means to access Mirena®. I understand assistance depends upon my ability to meet the eligibility criteria for the program. I also understand that the ARCH Foundation reserves the right at any time, and without notice, to modify the application form; to modify or discontinue this program and its eligibility criteria; or to terminate assistance. I authorize my clinician and my insurance company to disclose to the ARCH Foundation and its representatives information about me as deemed necessary to ensure the accuracy and completeness of this application. I understand that any personal information shown on this application will not be used for any purpose other than for the ARCH Foundation unless:

- I give written consent, or
- it is required or permitted under the law, or
- the ARCH Foundation first removes my name and any other identifying information

_____
Patient Signature Date

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