Compassionate Care Program

2013 PATIENT ENROLLMENT FORM

Phone: (855) 541-5926 Fax: (919) 415-2870

PATIENT INFORMATION Please remember that your program eligibility requires that you promptly notify the Compassionate Care Program by calling (855) 541-5926 if you become insured by any private or government insurance plan.

FIRST NAME		LAST NAME	MI
DATE OF BIRTH	GENDER ❒ Male ❒ Female	By providing your email address, you consent to receive additional mailings from the Compassionate Care Program. E-MAIL	
HOME PHONE		MOBILE PHONE	
MAILING ADDRESS		CITY / STATE / ZIP CODE	
PREFERRED METHOD OF CONTACT ❒ Home Phone ❒ Mobile Phone ❒ Mail ❒ E-mail		COUNTRY	

If you're unavailable when we call, is it ok for us to leave a message, including the Compassionate Care Program name? ❒ Yes ❒ No

TREATMENT

Are you currently undergoing fertility treatment with a fertility specialist? ❒ Yes ❒ No

Have you ever received products through the Compassionate Care Program in the past? ❒ Yes ❒ No

I have been prescribed the following:

❒ Any Gonal-f® (follitropin alpha for injection) product ❒ Cetrotide (cetrorelix acetate for injection) ❒ Ovidrel (choriogonadatropin alfa for injection)

Fax or mail your income verification form to the Compassionate Care Program:
Fax: (919) 415-2870 Mail: Compassionate Care Program • 6501 Weston Parkway, Suite 370 • Cary, NC 27513

We will need to know the annual adjusted gross income for the entire household. The following are acceptable income documents that we can use to validate your income:

- 1040 Form
- 1040 - A Form
- 1040 - EZ Form
- 1040 Form Married Filing Separately (MFS) Need a form from both filers
- 1040 - A Form (MFS)
- W2/1099R Form
- 1099 Form
- Pension Notification Letter
- Social Security Award Letter

How many people live in your household?

Patient Signature and Authorization:
Fax: (919) 415-2870 Mail: Compassionate Care Program • 6501 Weston Parkway, Suite 370 • Cary, NC 27513

My signature below certifies that I have completed all of the above sections completely, accurately, and to the best of my knowledge, and that I have read, understand, and agree to the terms of this enrollment form and the attached Authorization to Use and Disclose health and other personal information.

PATIENT SIGNATURE _____ DATE _____ PATIENT NAME _____

ART Center Contact or Site Name:
If applicable, please provide an email address for the person who manages the Compassionate Care program at your ART Center.

ART CENTER Texas Fertility Center

CONTACT E-MAIL jennifer.gus@txfertility.com or kimberly@txfertility.com

For assistance or additional information, call (855) 541-5926 Monday - Friday, 8:00 AM - 8:00 PM EST