

**VENOFER® PATIENT ASSISTANCE PROGRAM  
PATIENT APPLICATION**

**Patient Information**

Patient's Name: \_\_\_\_\_ Case number: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

**Provider Information**

Physician Name: \_\_\_\_\_  
Contact Person (other than physician): \_\_\_\_\_  
Facility/Practice Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Telephone : ( ) \_\_\_\_\_ FAX: ( ) \_\_\_\_\_

**Insurance Information**

Please provide data on insurers that provide health insurance benefits to this patient:

Insurer	Status	Plan Name	Effective Date
<input type="checkbox"/> Medicare	<input type="checkbox"/> Approved <input type="checkbox"/> Pending <input type="checkbox"/> Denied	_____	/ /
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Approved <input type="checkbox"/> Pending <input type="checkbox"/> Denied	_____	/ /
<input type="checkbox"/> Commercial	<input type="checkbox"/> Approved <input type="checkbox"/> Pending <input type="checkbox"/> Denied	_____	/ /
<input type="checkbox"/> Other	<input type="checkbox"/> Approved <input type="checkbox"/> Pending <input type="checkbox"/> Denied	_____	/ /
<input type="checkbox"/> Patient does not have and is not eligible for any public health insurance.			

**Financial Information**

Total annual household income (from most recent federal tax return): \$ \_\_\_\_\_

**Patient Certification and Consent**

- I would like to receive Venofer® free of charge from American Regent, Inc. (AR). I do not have, nor am I eligible for, any private or public health insurance or any other form of assistance with my medical expenses.
- I certify that the above information is correct to the best of my knowledge, and agree to notify the program of any changes. I understand that this information will not be used for any other purpose unless I give written consent, unless it is required by the government, or unless AR removes my name and any other identifying information.
- I understand that AR reserves the right to modify or discontinue this program with respect to any patient, or in its entirety, at any time. I also understand that, although Venofer® may be given to me without cost now, this does not mean I will be entitled to receive it without cost indefinitely.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Provider Certification Statement**

- I have determined that Venofer® is medically appropriate for the above named patient.
- I have received the consent of the above named patient to provide this information and to request assistance on his or her behalf.
- I agree to allow AR or an authorized AR representative to review the medical, financial, and insurance records for Program patients at any time for the purpose of verifying the patient's medical, financial, and insurance status and I have received the consent of the above named patient to do so.
- I understand that AR reserves the right to modify or discontinue this Program with respect to any patient, or in its entirety, at any time.
- I understand that no third party or patient may be charged for any Venofer® for which replacement product is sought under this Program.
- I represent that the information contained in this application is complete and accurate to the best of my knowledge and agree to notify the Program of any changes of which I become aware, which could affect the patient's eligibility status.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

*American Regent, Inc. reserves the right to modify or discontinue this program with respect to any patient, or in its entirety, at any time. AR also reserves the right to make an independent determination of medical indigence in all cases.*

Please send this completed form to: Venofer® Patient Assistance Program, c/o InTeleCenter™,  
P.O. Box 4280, Gaithersburg, MD 20885-4133. Phone: 800-282-7712 Fax: 240-632-3805