# BD PleurX™/PeritX™ Drainage System Patient Assistance Program

- ☐ **Attach Copy of Insurance Card (front and back)**
- ☐ **Attach proof of U.S. Residency (Ex: driver's license, recent utility bill)**
- ☐ **Attach proof of Income (Ex: IRS form 1040, Social Security award letter)**

Phone: 833-549-7677
Fax to: 312-949-0366
Email: GMB-PLEURXPTNAV-US@BD.com

## 1. Patient Information

*Attach proof of U.S. Residency – drivers license or state ID

Last Name: _____ First Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth (MM/DD/YYYY) : _____ Gender: ☐ Female ☐ Male

Primary Phone: _____ Email: _____

Patient consent to speak to Family Member/Other: Name: _____

Relationship: _____ Phone: _____

## 2. Patient Insurance Information

*Attach Copy of Insurance Card front and back

Does patient have health insurance? ☐ Yes ☐ No

Insurance Type: ☐ Commercial ☐ Medicare ☐ Medicaid ☐ Other

Primary Medical Insurance Provider: _____

Cardholder Name: _____ Insurance Phone#: _____

Policy/ID#: _____ Group#: _____

## 3. Patient Income

*Attach proof of Income: Recent pay stubs, Social Security Award Letter, 2 Months Banks Statements

Current Annual Household Income: $ _____ #People in Household: _____

## 4. Patient Enrollment Request

By signing below, I (or my authorized caregiver) am applying for enrollment into the BD PleurX™/PeritX™Patient Assistance Program (the Program). I understand and agree that: 1) BD may change or end the program at any time; 2) completing and signing this application does not guarantee my eligibility or acceptance into the Program; 3) there is no charge to participate in the Program if I am accepted into it; 4) I will not sell or trade any product that I receive through this Program; 5) I have an obligation to notify the Program within thirty (30) days if any changes in my income or health insurance impact my eligibility for this Program; and 6) the information I provided in this application is accurate and complete.

**Finally, I understand I/my caregiver may stop my participation in the BD PleurX™/PeritX™Patient Assistance Program at any time by calling 833-549-7677, faxing 312-949-0366 or by emailing GMB-PLEURXPTNAV-US@BD.com**

**Patient Name (please print):** _____

**Patient Signature:** _____ **Date:** _____

## 5. Patient Authorization for Financial Verification

I am providing 'written instructions' authorizing BD and / or its vendor providing credit check services, under the Fair Credit Reporting Act, to obtain information from my credit profile or other financial and/or health care coverage information from Experian Health, for the purpose of determining whether I financially qualify for programs administered by the Program. I understand that I must provide this authorization to proceed in this financial screening process. I promise that any information, including financial and insurance information, that I provide is complete and true. **If my income or health coverage changes, I will call the Program at 833-549-7677.**

**Patient Name (please print):** _____

**Patient Signature:** _____ **Date:** _____

## 6. Patient Authorization to Use and Disclose Health Information

I agree to the use and disclosure (sharing) of my protected health information and authorize my healthcare providers and staff, my health insurer, health plan or programs that provide me healthcare benefits (together, "Health Insurers"), and any distributor, DME or pharmacy that dispenses the product to disclose to Becton, Dickinson and Company and their agents (the "Manufacturer") health information about me including information related to my medical condition, diagnosis and treatment, health insurance coverage and claims, prescription (including fill/refill information), and referral to and enrollment in the BD PleurX™/PeritX™Patient Assistance Program described as "My Information" for the purposes of enrolling me in and providing certain services, including:

- To determine if I am eligible to participate in the Program
- Coverage determination or other support programs
- To investigate my health insurance coverage for the BD PleurX™/PeritX™Drainage System Kits
- To obtain prior authorization for coverage
- To assist with appeals of denied claims for coverage
- To assist with dispensing the product to me
- For the proper operation and administration of the Program and as permitted or required by applicable law
- To contact me or my healthcare provider for additional information to evaluate any adverse event or product complaint that I report or that my healthcare provider reports to me

Once My Information has been disclosed, I understand that privacy laws may not prevent further disclosure. However, the Program agrees to protect My Information by using and disclosing it only for the purposes allowed by me in this Authorization, or as otherwise allowed by law. I understand that my application into the Program is voluntary and that I do not have to complete or sign this Authorization. A decision by me not to sign this Authorization will not affect my ability to obtain medical treatment, insurance coverage, access to health benefits, or Manufacturer products. However, if I do not sign this Authorization, I understand that I will not be able to participate in the Program.

I understand that this Authorization shall remain in effect until my participation in the Program ends unless and until I withdraw (take back) this Authorization before then. Further, I understand that I may withdraw this Authorization at any time by mailing BD PleurX™/PeritX™Patient Assistance Program, 75 N Fairway Drive, Vernon Hills, IL 60061 or faxing a written request to 312-949-0366. Withdrawal of this Authorization will end my participation in the PleurX™/PeritX™Patient Assistance Program and will not affect any disclosure of My Information based on this Authorization made before my request is received and processed by my healthcare providers and staff, my Health Insurers, and specialty pharmacies.

I authorize the Program, Becton, Dickinson and Company (BD), their agents, and third-party contractors or their service providers authorized to administer the Program to use the information that I provided on this form to determine my eligibility for, and assist with my continued participation in, the Program.

## Patient's Authorization and Consent:

**Patient Name (please print):** _____

**Patient Signature:** _____ **Date:** _____