Patient Confidentiality Release Form
The Aventis Oncology PACT+℠ Program
Phone: 800-996-6626
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E-mail: ePACT@access2health.com

PACT PLUS℠
Providing Access to Cancer Therapy

The Aventis Oncology PACT+ Program is a reimbursement and product support program sponsored by Aventis Pharmaceuticals, a pharmaceutical manufacturer. We work with patients, physicians, and healthcare providers to:

- Understand your insurance coverage options
- Access benefits available through your insurance plan
- Appeal an insurance denial when possible
- Investigate coverage through other sources when necessary

In order for us to work to gather this information and advocate for reimbursement for your physician's prescribed course of treatment, we require your signature below, certifying that you understand that we are working on your behalf. Please read the information below carefully. When you understand it, please sign the form, fax it to the number above, and keep a copy for your records.

I, _____ , hereby authorize the following agents:

- My insurance company
- Prepayment organizations
- Aventis Oncology PACT+ Program and Reimbursement Services Group representatives
- Government agencies
- Employer
- Physician
- Aventis Pharmaceuticals
- Other healthcare providers

to collect and/or release all medical, financial, and patient information with respect to myself, that may have bearing on the benefits payable for services or products provided through the healthcare provider under any plan providing benefits or services, including (without limitations) the dollar balance of benefits remaining under any applicable lifetime maximum benefits provisions, or which may have bearing on my medical condition or compliance with therapy. I authorize the Aventis Oncology PACT+ Program and/or its agents, including Reimbursement Services Group representatives, to release such information to any of the persons or entities listed above for the purpose of seeking reimbursement assistance. I understand that the information identifying me will not be used for any purpose other than described above unless I have given my written consent.

I have read, understand, and agree to all of the above. A faxed copy of this agreement may be used as though it were the original. This release will be effective until revoked by me in writing.

_____
Print Patient or Guardian Name

_____
Print Witness Name

_____
Signature of Patient or Guardian

_____
Signature of Witness

_____
Date

_____
Date

Aventis
ONCOLOGY

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