Boehringer Ingelheim

CARES FOUNDATION

Boehringer Ingelheim Cares Foundation Inc.
Patient Assistance Program Application and Prescription Form

Instructions:

Patient – Complete Section 1 and return to your physician. (Make sure to include the required IRS and/or visa forms, if applicable).

Physician – Complete Section 2 and mail to: Boehringer Ingelheim Cares Foundation, Inc.
c/o Express Scripts Specialty Distribution Services, Inc.
P.O. Box 66555
St. Louis, MO 63166-6555
Tel: 800-556-8317 / Fax: 866-851-2827

Section 1 - Patient Information

Patient Name:	Date of Birth:	Male _____ Female _____

Street Address:	City:	State:	Zip Code:

SS#:	Telephone # with area code: ( )

U.S. Citizen? Yes_____ No_____ If no, please attach a copy of your visa	Number of Household members (including applicant)?	Are you a Veteran of the US Armed Forces? Yes ____ No ____

Did you file a U.S. State and/or Federal Income Tax return last year? Yes_____ No_____
If no, why not?

Prescription Insurance Status: Do you have prescription insurance coverage other than a Medicare Approved Discount Card (e.g., private insurance/HMO, Medicaid, Veteran Benefits, State Aid or other)? Yes_____ No ____

Do you currently have a Medicare Approved Drug Discount Card? Yes_____ No_____	If yes, do you receive the $600/year prescription drug credit? Yes_____ No_____

Have you used the entire credit this year? Yes_____ No_____

Total Gross Household Annual Income: $_____

Note: You must attach copy of your most recent U.S. Income Tax Return, i.e., IRS Form 1040, 1040A, 1040EZ, 1040NR or 1040PR, and copy of valid Visa if non-U.S. citizen.

I certify that this information is complete and accurate to the best of my knowledge, and that I am unable to afford the medication requested. I understand that additional information may be requested to process this application, but that all medical and financial information will be kept confidential, except as otherwise required by law. I understand that the Product(s) made available to me under this program may be denied to me if I do not fully cooperate with efforts made to verify the information provided in this Application, or if I do not take steps to secure alternative means of prescription coverage that are available to me after I become aware of such alternatives. I certify that I shall not seek reimbursement for any medication dispensed as part of this program.

I hereby authorize the program to obtain and disclose information from physicians, insurance companies and other information as necessary to verify the information provided in this application. Boehringer Ingelheim Cares Foundation, Inc. is not responsible for verifying any of the information contained in Section 2 below, including medical conditions, allergies, or other medications that I am taking.

Patient's Signature: Date:

Section 2 - Physician and Prescription Information

Physician Name:	Specialty:	Phone: ( ) Fax: ( )

Address: (no P.O. Box)	City:	State:	Zip Code:
	**State License #:	Exp. Date:	
	**DEA #:	Exp. Date:	
	** Completion of one of these two fields is required		

Prescription

Drug Name & Strength:	Directions:
Quantity (may not exceed 3-month supply):	
Drug Name & Strength:	Directions:
Quantity (may not exceed 3-month supply):	

Physician/Prescriber Attestation: To the best of my knowledge, this patient has no medical insurance (including Medicaid or other public programs) for this prescription. I verify that the information provided is complete and accurate to the best of my knowledge. I understand that the medication prescribed above shall be sent to my office for dispensing to this patient, and I certify that the medication requested above shall only be used to treat this patient and I shall not seek reimbursement for this medication from any third party.

Physician Signature: Date: