

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 <input type="checkbox"/> Male <input type="checkbox"/> 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 <input type="checkbox"/> Home Phone <input type="checkbox"/> Mobile Phone <input type="checkbox"/> Mail <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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-[®] (follitropin alpha for injection) product Cetrotide (cetrotirelix acetate for injection) Ovidrel (choriogonadotropin 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 Form Married Filing Separately (MFS) <small>Need a form from both filers</small>	- 1099 Form
- 1040 - A Form	- 1040 - A Form (MFS)	- Pension Notification Letter
- 1040 - EZ Form	- W2/1099R Form	- 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 _____
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ART Center Contact:
If applicable, please provide an email address for the person who manages the Compassionate Care program at your ART Center.

E-MAIL _____

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