Bayer US **Patient Assistance Foundation**

P.O. Box 5670, Louisville, KY 40255 / 1-866-2BUSPAF (228-7723)

Instructions

Reenrollment attestation form must be completed, signed and submitted to the Bayer US Patient Assistance Foundation by **December 31** if you wish to reenroll for the coming year. You may submit either online, fax or mail.

The reenrollment attestation form is for reenrolling Medicare patients ONLY. Patients applying for the first time to enroll in the Bayer US Patient Assistance Foundation must complete the full enrollment application. Please note, the Bayer US Patient Assistance Foundation cannot reenroll you without the completed, signed attestation form and a new prescription from your healthcare provider.

To submit **online:**

- Navigate to the Bayer US Patient Assistance Foundation website (www.patientassistance.bayer.us/en/resources)
- Click on "Submit Bayer US Patient Assistance Foundation Application online"
- Click on "SUBMIT DOCUMENTS"
- Upload the reenrollment attestation form as an attachment by scanning or taking a digital photo of the reenrollment attestation form.

To submit via **fax:** 1-866-575-6568

To submit by **mail:** Bayer US Patient Assistance Foundation, PO Box 5670, Louisville, KY 40255

Upon receiving the completed and signed reenrollment attestation form and new prescription from your provider, the Bayer US Patient Assistance Foundation will begin processing your request for enrollment and will notify you by mail as to your enrollment status for the coming year.

To speak with a Bayer US Patient Assistance Foundation representative, please call 1-866-228-7723, Monday through Friday, 9am to 6pm EST.

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Patient Attestation Form

Do you have any changes in health insurance information? No ☐ Yes ☐
Do you have any changes in household income? (other than cost of living adjustment) No ☐ Yes ☐
Has your home address changed? No ☐ Yes ☐
If you answered **Yes**, to any of the above questions, please complete the appropriate section below to update your information.

Please complete this section below ONLY IF you had any changes in health insurance information, household income, or US Residency.

Health Insurance Information (complete only in you have changes in health insurance information)

Insurer name _____
Plan name _____
Plan phone number (___)_____
Name of plan subscriber _____
Subscriber relationship to patient _____
Membership ID/policy # _____

Group # _____
Traditional Medicare ID # _____
Type ☐Commercial/Private ☐Medicare
☐Medicaid
☐Veterans Affairs/Dept. of Devense
☐State Elderly Drug Assistance
☐State Children's Health Insurance
☐Other

Household Income (complete only if you have a change in household income [other than cost of living])
How many people live in your household and are dependent on your household income (include yourself)? _____
What is your total household income? $ _____

Residence (complete only if your home address changed)
Mailing address: _____ City: _____ State: _____ ZIP: _____

Caregiver (optional)

Caregiver First Name _____ Last Name _____
Telephone number (___) _____ Relationship _____

I have spoken to my caregiver and they agree to receive non-marketing calls from the Bayer US Patient Assistance Foundation at the number provided, and I authorize the Bayer US Patient Assistance Foundation to speak to my caregiver about my health condition and regarding the program.

Please complete and sign the section below.

I acknowledge that submission of this reenrollment attestation form does not guarantee continued eligibility in the Bayer US Patient Assistance Foundation. I understand that to remain eligible for the Bayer US Patient Assistance Foundation free drug program, I must continue to meet the eligibility criteria. By signing below, I attest that the responses that I have provided are true and accurate.

Patient Name *(print)*: _____

Date of Birth: _____ Street Address: _____
City: _____ State: _____ Zip: _____

Patient Signature

_____ _____
(mm / dd / yyyy) Sign here
Date (required)

PAF-111-US-0149 10/23