# Patient Attestation Form

Bayer understands that sometimes people face financial challenges, and we are here to help. The Bayer US **Patient Assistance Foundation** is a charitable organization that helps eligible patients get their Bayer prescription medicine at no cost.

## Instructions

To reenroll in the Bayer US **Patient Assistance Foundation** (the "Foundation") for the coming year, complete, sign, and submit the patient attestation form by **December 31**. This applies only to **Medicare patients**; first-time applicants must fill out the full enrollment application.

## Where do I send my completed Patient Attestation Form?

The completed and signed form can be submitted online, via fax, or by mail:

### Online Submission

www.patientassistance.bayer.us

Visit the website, click on "Resources," then "Submit Bayer US **Patient Assistance Foundation** Application online," and select "SUBMIT DOCUMENTS" to upload your form.

Bayer US **Patient Assistance Foundation**
P.O. Box 5670, Louisville, KY 40255

**Fax:** 1-866-575-6568

**Questions? Call**
1-866-228-7723


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Bayer US **Patient Assistance Foundation**
P.O. Box 5670, Louisville, KY 40255 / 1-866-2BUSPAF (228-7723)

# Patient Attestation Form

Name _____ Date of birth ____/____/____ Sex ☐ Male ☐ Female
First Last ( mm / dd / yyyy )

Address _____ City _____ State _____ Zip code _____

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 questions above, please complete the relevant section below to update your information.

Complete the section(s) below **only if** your health insurance, household income, or US residency has changed.

## Patient Insurance Information - Do you have insurance through any of these providers. Check all that apply

☐ Medicare: ☐ Part A ☐ Part B ☐ Part C/Medicare Advantage ☐ Part D ☐ Part D LIS/Extra Help
☐ Medicaid ☐ VA or Military ☐ Private Insurance ☐ None ☐ Other:

| | Primary Insurance | Secondary Insurance | Prescription Insurance |
|---|---|---|---|
| Insurer name | | | |
| Plan name | | | |
| Plan phone number | | | |
| Name of plan Subscriber | | | |
| Subscriber relationship to patient | | | |
| Membership ID/Policy # | | | |
| Group | | | |
| Medicare Membership ID (11 digit alpha/numeric) # | _ _ _ _ - _ _ _ - _ _ _ _ | | ☐ Not applicable |

## Your Household Income

How many people live in your household and are dependent on your household income (include yourself)? _____
What is your total household income? $ _____

## US Residency

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 Foundation at the number provided, and I authorize the 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 patient attestation form does not guarantee continued eligibility in the Foundation. I understand that to remain eligible for the 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.

**Printed name of patient**

**Signature of patient (or legal representative)**

**Today's date MM/DD/YYYY**

**Printed name of legal representative** (if applicable)

**Relationship to patient** (if applicable)