



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



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 ☐ Uninsured. I do not have health insurance coverage.

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		
BIN		
PCN		
Medicare ID (Red/White/Blue) card	____ - ____ - ____ - ____ - ____ - ____	☐ 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)