PATIENT ENROLLMENT FORM

Please complete all fields with black ink and fax form to [1-844-250-7194].

Please send a copy of the patient's Explanation of Benefits.

For help, please call 1-877-329-8294. Available hours are Monday through Friday 8 AM - 5 PM (EST).

Patient Information

Last Name:	First Name:	MI:
Address:		
City:	State:	ZIP Code:
Telephone Number:	SSN:	
Email:		
Gender: ❒ Male ❒ Female	Date of Birth:	
Enter Factor Savings Card Member ID #:		
❒ Copy of explanation of Benefits attached		

Patient Insurance Information - Medical Card

Insurer Name:	Insurer Phone Number:
Member ID:	Group Number:

Patient Insurance Information - Prescription Card

Name:	BIN Number:	PCN Number:
Member ID:	Group Number:	
Policy Holder Name (if different from Patient):		

Physician Information

Physician Name:		
Address:		
City:	State:	ZIP Code:
Telephone Number:	Fax:	

Site Information

Site Name:		
Contact Name:	Contact Phone Number:	
Address:		
City:	State:	ZIP Code:
Telephone Number:	Fax:	

Enrollment Information

Please check one:

❒ Check here if applying for a Virtual Debit Card

❒ Check here if applying for reimbursement via check (Check will be sent to site using above site information)

Treatment Information

Drug:

Dosing:

Refills:

Please ensure that the fax and mailing information provided is correct and current. The fax number will be used to deliver the Virtual Mastercard information.

Please visit the Hemophilia Village website at www.hemophiliavillage.com to enroll into the Factor Savings Program and to obtain the 11-digit member number needed on this form.

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Healthcare Provider's Signature Date

By my signature, I certify that I am a physician or a healthcare provider authorized to sign on behalf of a physician and authorize the Factor Reimbursement Helpline and its agents (the "Helpline") to use any information provided on this form for the purposes of verifying coverage and benefits for Factor, or referring the patient to the Factor Savings Card Program in the event the patient does not have insurance. I certify that I have a signed copy on file of this patient's authorization (in a form that complies with all applicable state and federal laws) that allows me and the patient's health insurers to use and disclose the patient's health information, including his or her medical and insurance coverage information and records, to the Helpline, the Factor Savings Card Program, and their respective agents. I understand and agree that I remain responsible for complying with all applicable federal and state laws regarding patient privacy. The authorization form signed by the patient that I have on file informs the patient that: (a) the information disclosed may include the patient's health status; (b) the patient's information may be subject to re-disclosure by the recipients and no longer protected by state or federal privacy laws; (c) I will not condition the patient's treatment, payment, enrollment in a health plan, or eligibility for benefits on the patient providing the requested authorization; (d) the patient has the right to revoke the authorization at any time by calling the Helpline at 1-877-329-8294; (e) such revocation would end the patient's eligibility to participate in the program; and (f) if the patient revokes the authorization, the revocation will prohibit disclosures after the date the written revocation is received, but will not affect previous disclosures made in reliance on the patient's authorization. The patient's signature will be maintained and available for audit purposes as required by all applicable state and federal privacy laws. To the best of my knowledge, all information contained in this form is correct and complete and consistent with applicable privacy laws and regulations, and I understand that the Helpline is relying on this representation. I further certify that I made the above prescribing decisions based on my own independent medical judgment regarding what is in the best interests of the patient.