

# 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-<sup>®</sup> (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 or Site Name:**  
 If applicable, please provide an email address for the person who manages the Compassionate Care program at your ART Center.

ART CENTER
CONTACT E-MAIL
<b>For assistance or additional information, call (855) 541-5926 Monday - Friday, 8:00 AM - 8:00 PM EST</b>