Compassionate Corps Program

PATIENT ENROLLMENT FORM

This program is secondary to coverage provided under the Fertility Veterans Act (Pub. Law 114-223) and does not apply to veterans eligible for coverage under the Act.

Fax: 1-866-882-2900

APPLICANT INFORMATION

FIRST NAME	LAST NAME	MI

DATE OF BIRTH	GENDER ☐ Male ☐ Female	By providing your e-mail address, you consent to receive additional mailings from the Compassionate Corps Program. E-MAIL

HOME PHONE	MOBILE PHONE

MAILING ADDRESS	CITY	STATE	ZIP CODE

RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse/Life Partner ☐ Other	PRIMARY CONTACT ☐ Yes ☐ No

If you're unavailable when we call, is it ok for us to leave a message, including the Compassionate Corps Program name? ☐ Yes ☐ No

PATIENT INFORMATION

FIRST NAME	LAST NAME	MI

DATE OF BIRTH	GENDER ☐ Male ☐ Female	By providing your e-mail address, you consent to receive additional mailings from the Compassionate Corps Program. E-MAIL

HOME PHONE	MOBILE PHONE

MAILING ADDRESS	CITY	STATE	ZIP CODE

RELATIONSHIP TO APPLICANT ☐ Self ☐ Spouse/Life Partner ☐ Other	PRIMARY CONTACT ☐ Yes ☐ No

If you're unavailable when we call, is it ok for us to leave a message, including the Compassionate Corps Program name? ☐ Yes ☐ No

ELIGIBILITY INFORMATION

Service-related injury/illness? ☐ Yes ☐ No	Does the injury/illness sustained affect your natural procreative abilities? ☐Yes ☐No

Are you retired from the military? ☐ Yes ☐ No

Branch of military service?_____	Dates of service? From: _____ To: _____

Your physician has indicated that you require assisted reproductive technology (such as IVF). Do you have insurance coverage for this type of treatment?

☐ Yes ☐ No

PLEASE ATTACH A COPY OF YOUR DD-214, A DENIAL OF BENEFITS LETTER, AND ANY MEDICAL INFORMATION/RECORDS RELEVANT TO YOUR APPLICATION

Please note: This program is valid for a maximum of 2 cycles per calendar year.

FAX OR MAIL YOUR FORM AND SUPPORTING DOCUMENTS TO THE COMPASSIONATE CORPS PROGRAM

Fertility LifeLines™
12 Kent Way
Byfield, MA 01922
Attn: Compassionate Corps Program
Fax: 1-866-882-2900

PATIENT SIGNATURE AND AUTHORIZATION

Fax: 1-866-882-2900

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 form. This coverage is secondary for those ineligible for coverage under the VA Bill. I commit to making the Compassionate Corps Program aware, if at any time, I gain insurance coverage for infertility treatment. No units of product received under this program will be submitted for Medicare, Medicaid, TRICARE, the Department of Veterans Affairs, the Department of Defense, or any public or private third-party reimbursement, or returned for credit.

Please remember that your program eligibility requires that you promptly notify the Compassionate Corps Program by calling (866) 538-7879 if you become insured by any private or government insurance plan.

PATIENT SIGNATURE	DATE
PATIENT NAME	

ART Center Contact:

If applicable, please provide an e-mail address for the person who manages the Compassionate Corps Program at your ART center.

E-MAIL_____

Authorization to Use and Disclose Health and Other Personal Information

Patient's Name _____

Address _____

Home Phone _____

DOB _____/_____/_____

I authorize my physician and his/her staff to disclose my health and other personal information, including, but not limited to, the information on the Patient Enrollment Form, the Compassionate Corps Product Request Form or any other form I may complete in connection with EMD Serono programs, to EMD Serono, Inc. and its agents and representatives, including the companies that help administer EMD Serono's Compassionate Corps Program or other EMD Serono programs I may apply for (collectively "EMD Serono"), so that EMD Serono may use and further disclose my information to healthcare providers, pharmacies, insurance companies, prescription drug plans and other third-party payers (collectively, "Third Parties") in order to:

(1) contact me by mail, e-mail, and/or telephone to enroll me in and administer EMD Serono's Compassionate Corps Program or any other EMD Serono program I may apply for;

(2) facilitate the filling of my prescription for and the delivery and administration of EMD Serono medication in connection with EMD Serono's Compassionate Corps Program or any other EMD Serono program I may apply for;

(3) provide me with materials relating to EMD Serono's Compassionate Corps Program or any other EMD Serono program I may apply for;

(4) verify the accuracy of the information I provide in my application for EMD Serono's Compassionate Corps Program or any other EMD Serono program I may apply for; and

(5) conduct surveys to measure my satisfaction with EMD Serono's Compassionate Corps Program or any other EMD Serono program I may apply for.

I further authorize the Third Parties to disclose health and other personal information about me in their possession to EMD Serono in order to assist EMD Serono in accomplishing the purposes described above.

PATIENT MUST COMPLETE AND FAX BACK THIS FORM AND THE ENROLLMENT FORM

I understand that once my information is disclosed pursuant to this authorization, there is no guarantee that it will not be disclosed to another third party. However, I understand that EMD Serono will not release my information to any party, except as provided in this authorization or as permitted by applicable law, without first obtaining my (or my authorized representative's) separate written consent.

I understand that I may refuse to sign this authorization and such refusal will not affect my ability to receive EMD Serono medications, but it will limit my ability to participate in EMD Serono's Compassionate Corps Program or any other EMD Serono program I may apply for.

I understand that this authorization will remain in effect for ten years from the date of my signature, unless I revoke it earlier by contacting EMD Serono in writing at One Technology Place, Rockland, MA 02370. If I revoke this authorization, EMD Serono will stop using and disclosing my information as soon as possible, but the revocation will not affect prior use or disclosure of my information in reliance on this authorization.

I understand that the services provided by EMD Serono that are described in this authorization can be changed at any time, without prior notification.

I also understand that I have the right to receive a copy of this authorization.

Patient name (please print): _____

Signature of patient (or personal representative): _____ Date: _____

Authority/relationship of personal representative (if applicable): _____

PATIENT MUST COMPLETE AND FAX BACK THIS FORM AND THE ENROLLMENT FORM