



Please complete each section to the fullest extent possible and return this confidential enrollment application to the Betaseron Patient Assistance Program. If an item does not apply, please note "N/A" on that line. If you have any questions about the application, please call the Betaseron Patient Assistance Program at 1-877-836-5724.

Section 1 – Patient Information

Patient Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Telephone: _____ Work or Alternate Telephone: _____
OK to leave message? Yes No OK to leave message? Yes No
Date of Birth: _____ Gender: _____ Social Security #: _____

Section 2 – Insurance Information

I have no insurance coverage, including Medicare, Medicaid, VA, Department of Defense or other similar governmental assistance (Skip to Section 3).

Primary Insurance Information (including Medicare, Medicaid, VA, Department of Defense or other similar governmental assistance)

Payer Name: _____
Policy #: _____ Group #: _____
Subscriber Name: _____
Subscriber Date of Birth: _____
Does this plan cover prescription drugs? Yes No

Secondary Insurance Information (including Medicare, Medicaid, VA, Department of Defense or other similar governmental assistance)

Payer Name: _____
Policy #: _____ Group #: _____
Subscriber Name: _____
Subscriber Date of Birth: _____
Does this plan cover prescription drugs? Yes No

Section 3 – Public Programs

Have you applied for Medicare, Medicaid, VA, Department of Defense or other similar governmental assistance?

Yes Program Name: _____
Date Applied: _____
Status of Application: Approved Pending Denied

If denied, please enclose copy of denial

No Do you intend to apply? Yes No
If not, why? _____

Section 4 – Financial and Other Information

Annual Household Income: _____ # of household members dependent on income: _____
Annual household out-of-pocket medical expenses not reimbursed by insurance (please EXCLUDE costs for Betaseron):
Hospital \$ _____ Doctor \$ _____ Drugs \$ _____
Other \$ _____ Portion of health insurance premium you pay \$ _____

Section 5 – Required Documentation

Please submit a copy of the following with your application:

1. Income verification for all sources of household income, including:
 - Copy of your most recent federal tax return
 - Statement of Social Security benefits
 - Statement of pension benefits
 - Statement of disability benefits
 - Statement of alimony and/or child support received
 - Unemployment benefits
2. Copy of your insurance card(s) and insurance denial for Betaseron, if applicable. Please provide copies of both the front and back of your insurance cards.

Section 6 – Patient Declaration

By providing my signature below, I authorize Bayer HealthCare Pharmaceuticals Inc. (“Bayer”) and its Healthcare Partners to use and disclose the information on this form to permit Bayer, its Healthcare Partners, my physician, pharmacy, insurance company, or other third-party payors to contact me and provide me with educational or product information materials, surveys or other information or materials about products or services that may be of interest to me. Bayer’s Healthcare Partners may receive compensation for providing literature and marketing services. I verify that the information provided in this application form is current, complete, and accurate, and understand that it will be reviewed and relied upon to determine my eligibility for free product under the Betaseron Patient Assistance Program (the “Program”). I understand that any assistance in the form of free product is contingent upon my ability to meet the eligibility criteria for the Program. The Program also reserves the right to make an independent determination of financial and medical need. I also understand that Bayer reserves the right at any time, and without notice, to modify or discontinue the Program with respect to any patient, or in its entirety. I authorize the Program to use and obtain information from my prescribing physician, insurance company, and other sources as deemed necessary to ensure the accuracy and completeness of this application to administer the Program. I understand that the Program will use and give out my information to help me with my reimbursement questions, to see if I qualify for free product through patient assistance, or to refer me to, or determine my eligibility for, other programs, foundations, or alternate sources of funding or coverage to help me with the costs of obtaining Betaseron. I acknowledge that I am a legal resident of the United States. I authorize my health care providers, health plans, and health insurers to use and disclose to Bayer and the Program and their authorized agents and assignees, all medical records and financial information with respect to my treatment and my eligibility for treatment. I understand that I may not, and agree that I will not, seek reimbursement from any private insurance or public assistance program for any Betaseron made available to me under the Program.

Patient Signature

Date

Please return this completed form to:
Betaseron Patient Assistance Program
PO Box 221349
Charlotte, NC 28222-1349
Toll free fax 1-877-744-5615

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