Boehringer Ingelheim

CARES FOUNDATION

Patient Assistance Program

Patient – Complete Section 2 and return to your physician. (Make sure to include the required IRS and/or visa forms, if applicable).

Physician – Complete Section 1 and return to:

Mail to: Boehr[illegible]oundation, Inc.
c/o Express Scripts SDS, Inc.
P.O. Box 66555
St. Louis, MO 63166-6555
Questions? Call 1-800-556-8317
Fax: 866/851-2827

Reset Form

Section 1 - Physician and Prescription Information			
Physician Name	DEA or State License #:	Phone: ( ) Fax: ( )	
Address:	City:	State:	Zip:

Prescription	
Product Name/Strength	**Quantity**
Product Name/Strength	**Quantity**

Physician/Prescriber Attestation: To the best of my knowledge, this patient has no medical insurance (including Medicare, Medicaid, or other public programs) for this prescription. I verify that the information provided is complete and accurate to the best of my knowledge. I understand that the medication prescribed above shall be sent to my office for dispensing to this patient, and I certify that the medication requested above shall only be used to treat this patient and I shall not seek reimbursement for this medication from any third party.

Physician Signature:	Date:

Section 2 - Patient Information			
Patient Name:		SS#: - -	
Street Address:		Date of Birth: / /	Male ☐ Female ☐
City	State	Zip	Phone ( )

Number of Household members (including self)? (circle one) 1 2 3 4 5 6 7 greater than 7	U.S. Resident? Yes ☐ No ☐	Are you a Veteran of the US Armed Forces? Yes ☐ No ☐	Are you Disabled? Yes ☐ No ☐

Financial Information **Note:** You must attach copy of your most recent U.S. Income Tax Return, i.e.,IRS Form 1040, 1040A, 1040EZ, 1099

List All Sources, Gross Monthly Amounts

Salary/Wages $_____ Social Security $_____ Child Support/Alimony $_____

Disability $_____ Pension/ Retirement $_____ Unemployment/ Work Comp $_____

Total Gross Household Monthly Income: $_____

Total Patient Assets: $_____ (This includes savings/checking, IRA, annuities, stocks/bonds/CDs)

Private Drug Coverage	**Medicaid**	**Medicare**	**Medicare Part D**
☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

I certify that this information is complete and accurate to the best of my knowledge, and that I am unable to afford the medication requested. I understand that additional information may be requested to process this application, but that all medical and financial information will be kept confidential as required by law. I understand that the Product(s) made available to me under this program may be denied to me if I do not fully cooperate with efforts made to verify the information provided in this application, or if I do not take steps to secure alternative means of prescription coverage that are available to me, after I become aware of such alternatives. I certify that I shall not seek reimbursement for any medication dispensed as part of this program.

I hereby authorize the Boehringer Ingelheim CARES Foundation, Inc. to obtain and disclose information from physicians, insurance companies and other information as necessary to verify the information provided in this application although Boehringer Ingelheim CARES Foundation, Inc. is not obligated to verify any of the information contained in Section 1 above or confirm other medications that I am taking.

Patient's Signature:	Date: