

# Grifols Assurance for Patients (GAP) Enrollment Form

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Parent/Guardian: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apartment Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Health Insurance Coverage: \_\_\_\_\_ Insurance Telephone: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Other Health Insurance Coverage: \_\_\_\_\_ Insurance Telephone: \_\_\_\_\_

## Patient Certification

I attest that the above information is correct and complete. I agree to notify Grifols immediately should any of the information provided above changes. I understand that this is short term assistance and that no third party payer may be charged for product received through the GAP program and that no product received through this program can be sold, traded or distributed for resale. I give my written consent authorizing Grifols and/or its representative to contact my insurer and healthcare provider to determine my eligibility under this program. I understand that Grifols and/or its representatives, in compliance with the relevant sections of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, will not disclose any information obtained from these sources to any third party not related to this service except when required by applicable law. I understand and hereby certify that I have attempted to obtain insurance coverage, but that at this time, I am not eligible for any private health insurance, state or federal insurance programs or financial assistance programs. I understand that Grifols reserves the right at any time and without notice to modify the program enrollment form; modify or discontinue any or all of the program and related eligibility criteria; or terminate assistance provided by the program. I understand that Grifols reserves the right to approve or deny any request for program assistance. I understand that GAP is not an emergency program and that it may take a maximum of 5 business days from the date of receipt of the completed information to determine eligibility and whether product shipment will be made. Current eligibility requirements include, but are not limited to: Patient must have been utilizing Alphanate<sup>®</sup>, AlphaNine<sup>®</sup> SD or Profilnine<sup>®</sup> SD for three months prior to a lapse in coverage through a non-government health insurance plan and Patient must be a US citizen or has legal resident status. Patient also understands that product to be provided under GAP is based on Grifols' inventory availability. It is recommended that Patient (or Guardian, if applicable) will monitor the amount of benefits remaining on the Patient's policy and provide the GAP representative a sixty (60) day notification prior to exceeding the lifetime maximum benefit of the Patient's non-governmental health insurance plan.

\_\_\_\_\_  
*Patient Signature (Parent/Guardian if applicable)*

\_\_\_\_\_  
*Date*

Prescribing Physician: \_\_\_\_\_ Physician Phone: \_\_\_\_\_

Factor Provider Name: \_\_\_\_\_ Factor Provider Phone: \_\_\_\_\_

Grifols Factor Product: \_\_\_\_\_ Medical Record Number: \_\_\_\_\_

Start of Therapy Date: \_\_\_\_\_ Date Product is Needed: \_\_\_\_\_

Quantity of Units: \_\_\_\_\_ Dosage and Frequency: \_\_\_\_\_

Yearly Utilization: \_\_\_\_\_

## Physician Certification

I attest that the information provided is correct and complete. In the event that there are any changes to this information, I agree to notify the GAP Program. I understand that no third party or patient may be charged for product received through this program and that no product received through this program can be sold, traded, distributed for resale or used by another individual. I understand that Grifols reserves the right at any time and without notice to modify this application; modify or discontinue any or all of the program; or terminate assistance provided by the program. I understand and hereby certify that the Patient is not actively participating in any state or federal insurance programs or financial assistance programs.

\_\_\_\_\_  
*Physician Signature*

\_\_\_\_\_  
*Date*

Please return the completed form to confidential FAX (323) 441-7166 and mail hard copy to: Grifols PatientCare Program, P.O. Box 3745, Alhambra, CA 91803-3745

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**GRIFOLS**