

Grifols Patient Assistance Program - Application

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 change. I understand that this is short term assistance and that no third party payer may be charged for product obtained through the Grifols Patient Assistance 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 (HIPPA) 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 this application; 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 this program is not an emergency program and that it may take a maximum of 5 business days from the date of receipt of the complete information to determine eligibility and whether product shipment will be made. Current eligibility requirements include, but are not limited to: Patient must be a U.S. citizen or have legal resident status; patient must not be eligible for Medi-Cal share of cost or Medicaid Spend-down and Patient should meet financial eligibility of 250% of the Federal Poverty level. Patient also understands that product to be provided under Grifols Patient Assistance Program is based on Grifols' inventory availability.

Patient Signature (Parent/Guardian if applicable)

Date

Prescribing Physician: _____ Physician Phone: _____

Provider Name: _____ Provider Phone: _____

Grifols Product: _____ Medical Record Number: _____

Start of Therapy Date: _____ Dosage and Frequency: _____

Annual Household Income: _____ Number of Persons in Household: _____

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 Grifols Patient Assistance 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 and related eligibility criteria; 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

Working for health since 1940

GRIFOLS