Compassionate Care Program

Compassionate Care

PATIENT ENROLLMENT FORM

Phone: (855) 541-5926 Fax: (919) 415-2870

PATIENT INFORMATION Please remember that your program eligibility requires that you promptly notify the Compassionate Care Program by calling (855) 541-5926 if you become insured by any private or government insurance plan

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 Care Program. E-MAIL
HOME PHONE	MOBILE PHONE	
MAILING ADDRESS	CITY / STATE / ZIP CODE	
PREFERRED METHOD OF CONTACT ☐ Home phone ☐ Mobile phone ☐ Mail ☐ E-mail	COUNTRY	

Please indicate if you or your partner are active, veteran or retired US Military: ☐ Yes (Indicate branch):_____ ☐ No

Please indicate your dates of service. From _____ Until_____ (Month/Day/Year)

FAX OR MAIL YOUR INCOME VERIFICATION FORM TO:
Fax: (919) 415-2870 Mail: The Compassionate Care Program • 2250 Perimeter Park Drive, Suite 300 • Morrisville, NC 27560

We will need to know the annual adjusted income for the entire household. The following are acceptable income documents that we can use to validate your income:

☐ 1040 Form
☐ 1040A Form
☐ 1040EZ Form
☐ 1040 Form Married Filing Separately (MFS) (Need a form from both filers)
☐ 1040A Form (MFS)
☐ 1099 Form

How many people live in your household?

PATIENT SIGNATURE AND AUTHORIZATION:
Fax: (919) 415-2870 Mail: Compassionate Care Program • 2250 Perimeter Park Drive, Suite 300 • Morrisville, NC 27560

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 and Other Personal Information form. If I am an active duty or retired military member, I commit to making the Compassionate Care Program aware, if at any time, I gain private insurance coverage for infertility treatment. If I am not an active duty or retired military member, I commit to making the Compassionate Care Program aware, if at any time, I gain any insurance coverage for infertility treatment. No units of product received under this program or any medical expenses related to my fertility treatment 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, as discussed above, your program eligibility requires that you promptly notify the Compassionate Care Program by calling (855) 541-5926 if you become insured by any private or government insurance plan.

PATIENT SIGNATURE	PATIENT NAME	DATE

ART CENTER CONTACT OR SITE NAME:
If applicable, please provide an e-mail address for the person who manages the Compassionate Care Program at your ART Center.

ART CENTER	CONTACT E-MAIL

For assistance or additional information, call (855) 541-5926 Monday to Friday, 8:00 AM to 8:00 PM EST