

FAX COMPLETED FORM TO:
COMMITMENT TO CARE: (866) 277-9328 (oncology)
(800)-683-7855 (hepatitis C)

IF YOU HAVE ANY QUESTIONS CALL:
COMMITMENT TO CARE (800) 521-7157

COMMITMENT TO CARE APPLICATION

DATE SUBMITTED:

PATIENT INFORMATION

PATIENT NAME:	SOCIAL SECURITY #: DATE OF BIRTH:	
ADDRESS:		
CITY:	STATE:	ZIP:
SEX:	PHONE NUMBER:	
PRESCRIBED MEDICATION:	DIAGNOSIS:	
MARITAL STATUS:	HOUSEHOLD SIZE:	
TOTAL MONTHLY GROSS INCOME:	***MUST PROVIDE PROOF OF INCOME, SEE LIST ON PAGE 2***	

INSURANCE INFORMATION –

PLEASE INCLUDE COPY OF CARD (FRONT AND BACK)

PRIMARY CARRIER NAME:		
TELEPHONE NUMBER:		
NAME OF POLICY HOLDER WITH DATE OF BIRTH:	POLICY ID#:	GROUP #:
SECONDARY CARRIER NAME:		
TELEPHONE NUMBER:		
NAME OF POLICY HOLDER WITH DATE OF BIRTH:	POLICY ID#:	GROUP #:
OTHER CARRIER NAME: (IE., VA, RAILROAD RETIREMENT)		
TELEPHONE NUMBER:		
NAME OF POLICY HOLDER WITH DATE OF BIRTH:	POLICY ID#:	GROUP #:

MEDICARE PART D

HAVE YOU APPLIED?: ☐YES ☐NO ☐PENDING

DATE APPLICATION WAS SUBMITTED: _____IF NOT ELIGIBLE, REASON FOR DENIAL:_____

STATE PROGRAM INFORMATION	
MEDICAID	**OTHER STATE PROGRAMS**
HAVE YOU APPLIED?: ☐YES ☐NO ☐PENDING	HAVE YOU APPLIED?: ☐YES ☐NO ☐PENDING
DATE APPLICATION WAS SUBMITTED: _____	DATE APPLICATION WAS SUBMITTED: _____
IF NOT ELIGIBLE, REASON FOR DENIAL:_____	IF NOT ELIGIBLE, REASON FOR DENIAL:_____

HEALTH CARE PROVIDER INFORMATION ***PLEASE INCLUDE COPY OF CURRENT RX IF REQUESTING DRUG ASSISTANCE***		
PHYSICIAN PRACTICE NAME:	TAX ID # :	
PHYSICIAN NAME:	MEDICAID PROVIDER # W/ PIN (IF APPLICABLE):	BLUE CROSS/BLUE SHIELD PROVIDER # W/ PIN:
ADDRESS:	DEA#:	
CITY:	STATE:	ZIP:
TELEPHONE NUMBER:	FAX NUMBER:	
OFFICE CONTACT PERSON:		

Please include the following documentation when submitting this application for consideration into Schering's COMMITMENT TO CARE Program:

- Copy of Rx (if applicable)
- Medicaid Eligibility Denial Letter (if applicable)
- Copies of Insurance Cards Front and Back (if applicable)
- Proof of Gross Monthly **Household** Income In <u>One</u> of the forms listed below:
    - W-2s or Tax Returns (if not available, please provide one of the following):
        - Checking Account Statements (3 months worth)
        - Pay Stubs
        - Social Security Benefit Award Letter
        - If Zero Income:
            - Notarized Letter of Support from Family or
            - Zero Income Letter from Physician

<u>Patient Acknowledgment and Consent</u>

The COMMITMENT TO CARE program is a service of Schering Corporation. Collection of certain insurance, financial, and medical information is necessary in order to evaluate your enrollment into the program and, if enrolled, to provide you program services. The program services include verifying your insurance benefits, identifying potential alternative benefits for which you may be eligible, and/or evaluating you for participation in the COMMITMENT TO CARE program. Except as discussed below, and except as permitted or required by law, this private medical, insurance, and financial information will be kept confidential and will not be shared with any third parties. Your information may be shared or disclosed in order to fully evaluate you for initial and continued enrollment in the program. For example, personal information may also be shared with physicians and health insurers in order to provide you with program services. In addition, we are required to report certain personal information to Schering Corporation in order to comply with FDA reporting requirements. Finally, nonidentifiable information from all program participants may be summarized for statistical or other purposes, but your identity cannot be determined from this summary information. By enrolling in COMMITMENT TO CARE, you are agreeing to this acknowledgment and consent.

Patient Name (please print)_____
Patient Signature_____**Date**_____
Legal Representative/Guardian Signature_____**Date**_____
(if applicable)