# PATIENT ASSISTANCE PROGRAM APPLICATION

Fax: 1-844-528-3322 Phone: 1-844-528-3311 Email: Info@AvedroARCH.com

## PATIENT FINANCIAL

| | | | |
|---|---|---|---|
| First Name: | Middle Initial: | Last Name: | |
| Address: | City: | State: | Zip Code: |
| Date of Birth: | SS#: | Gender: Male ☐ | Female ☐ |
| Patient legal guardian name (if patient is under 18): | | # of Household Members: | |
| Household Adjusted Gross Income: | Coverage Type: | | |

## SITE INFORMATION

Treating Site Requesting Assistance:

| | |
|---|---|
| Rendering Physician Name: | Treating Site Tax ID ☐ or NPI ☐: |

Site of Service: ☐ Physician's office ☐ Hospital outpatient ☐ Ambulatory surgical center

## TREATMENT

| | | |
|---|---|---|
| Diagnosis 1: | CPT® code 1: | Side(s) being treated (check all that apply): RT LT |
| Diagnosis 2: | CPT® code 2: | Bilateral: ☐ |
| | | Anticipated date of treatment: _____/_____/_____ |
| | | Not yet scheduled: ☐ |

## PATIENT CERTIFICATION

I understand that, if I am determined to be an eligible patient, my physician cannot charge me in excess of $500 for the procedure.

By signing this form, I certify that the information provided on this application and in any accompanying materials or documents I have provided is true, accurate, and complete to the best of my knowledge. I understand that EVERSANA, as the administrator for the Avedro ARCH Patient Assistance Program, will use this information to determine my eligibility for patient assistance. I certify that I do not have prescription drug or medical coverage under any commercial (private) insurance plan. I understand that eligibility in this program is subject to meeting income criteria. I understand that my enrollment in the Program is determined at the sole discretion of Avedro, via its administrator. No identifiable information about me will be provided to Avedro. I acknowledge that Avedro reserves the right to modify or terminate the Patient Assistance Program at any time without prior notice.

Sign and date here

Patient/Guardian Signature: _____ Date: _____/_____/_____

**Please complete this application and submit by fax to 1-844-528-3322.**