ACELL, INC. INDIGENT CARE APPLICATION
Phone__________: | compliance@acell.com

Patient Information

____ ❐ ❐ _______/______/________

Name (Please PRINT First, Middle Initial, Last) Male Female DOB: Month Day Year

____ ______________________________ ______ ______________

Street Address City State Zip Code

____________________ ____________________ ____________________ ____

Home Telephone Work Telephone Mobile Telephone Email Address

____

Parent or Legal Representative (First, Last) and Relationship

Is the patient a U.S. Citizen? ❐ Yes ❐ No **(If no, please provide proof of U.S. residency, such as a copy of Green Card or other government issued ID that identifies the patient's address)**

Financial Information

Please indicate the Adjusted Gross Income of the patient's household as it appears on the most recent year's federal tax return (e.g., IRS Form 1040 or 1040EZ):

Adjusted Gross Income:_________________ Year:_____________

- Please attach a copy of the patient's most recent year's federal tax return(s) (IRS Form 1040 or 1040 EZ) as well as the W2 form(s) that document household size and income. The application cannot be processed without this documentation.
- In the event the patient did not file a federal tax return last year, please provide a notarized statement of the patient's annual household income.

Marital Status: ❐ Married ❐ Single ❐ Domestic Partner

Household size based on IRS Form 1040 or 1040 EZ (number of persons dependent upon total household income):_________

Insurance Information

Does the patient currently have health insurance? ❐ Yes ❐ No

If Yes:

____ ______________________________ ______________________________

Primary Insurance Company/Provider Insurance Telephone ID #

_________________ ____________________ ____

Policy # Group # Policy Holder Name (First, Last) and Relationship to Patient

____ ______________________________ ______________________________

Secondary Insurance Company/Provider Insurance Telephone ID #

_________________ ____________________ ____

Policy # Group # Policy Holder Name (First, Last) and Relationship to Patient

If No:

____ ______________________________

Name of Patient's Most Recent Insurance Company/Provider Date that Coverage Ended

Has the patient applied for/does the patient believe s/he qualifies for Medicaid or any other state funded program assistance? ❐ Yes ❐ No
(If the patient applied for Medicaid/state program assistance and was denied, please indicate the reason for denial:
____)

Does the patient have insurance coverage from/participate in any of the following insurance programs? (Check all that apply):

❐ Medicare
❐ Medicaid

- ❒ Veterans Administration
- ❒ TriCare/CHAMPUS
- ❒ Indian Health Services
- ❒ Public Health Services
- ❒ Any other Federal or state healthcare program(s), please list:____

____

Treating Physician Information

____ _____________________________ ______________________________

Name (Please PRINT First, Middle Initial, Last) Telephone Fax

____ _________________________________ _______ ________________

Street Address City State Zip Code

____ _________________________________ _________________________

Facility Name National Provider # State Medical License #

Treating Physician / Institutional Officer Attestation

By signing this form, I represent that I have obtained all necessary Federal and state authorizations and consents from my patient to allow me to release health information to ACell and its contracted third parties in connection with their application for and continued eligibility for assistance from ACell's Indigent Care Program (the "Program").

I represent that the information contained in this application is complete and accurate. I certify that the diagnosis is medically accurate and indicated for this patient and that I will be supervising this patient's treatment. I understand that ACell reserves the right to modify or terminate the Program at any time. I acknowledge that I shall not seek reimbursement from any insurer or government program for any treatment dispensed hereunder. Furthermore, my signature certifies that these goods will not be resold nor offered for sale, trade, or barter and will not be returned for credit. I understand that ACell reserves the right to recall the product, if necessary. Absent receipt of the donated product, the patient would charge the patient directly for the cost of the product. I understand that there is no guarantee that any patient will receive assistance from the Program and my submission of the information below is not made in exchange for or in connection with any explicit or implicit agreement or understanding that I have or will in the future recommend, order, or use ACell product(s) for my patients, or recommend preferential or qualifying status for ACell products.

Original Signature of Licensed Practitioner/Institutional Officer (no stamps accepted) ___________________________________Date__________________

TREATMENT REQUESTED:

Patient Name:____ Patient Date of Birth:______________________

Product (please select):

Patient Certification, Disclaimer and Authorization

I verify that the information provided in this application is complete and accurate to the best of my knowledge. I understand that if my health insurance coverage or financial status changes, I will notify ACell promptly of such change. I understand that this may affect my eligibility to participate in the Program before my eligibility period ends. I also understand that any and all information that I provide to the Program may be shared with my treating physician and with ACell (including its representatives, agents, and contractors) to the extent necessary to administer the Program and ensure my continued eligibility to receive Program support. I understand that this confidentiality waiver will remain in effect throughout my participation in the Program unless I notify ACell; however, I understand that my participation in the Program is contingent upon my having a valid confidentiality waiver in place. The Program may be discontinued or modified at any time, without prior notice. Program support is not guaranteed to all applicants. The Program does not cover or provide support for procedures or any physician related services associated with the patient's therapy. Patients must reapply annually and will be reassessed for continuing eligibility on a quarterly basis.

Patient Signature (original signature required):

____ Date:_________________

(If Patient is a Minor): Parent/ Legal Representative Signature:

____ Date:_________________

If signed by a Legal Representative, please describe your authority to act on behalf of the patient:____

Please return the completed application form and required documentation attention to: compliance@acell.com**.**

If there are questions regarding the completion of the form please call Professional Relations at 443-283-2765 or 410-953-8531