Bristol-Myers Squibb

Patient Assistance Foundation

Phone: **800-736-0003**
Monday to Friday, 8:00 AM – 8:00 PM ET
(excluding holidays)

BMSPAF Case #:

PO Box 220769, Charlotte, NC 28222-0769 | Phone: 800-736-0003 | Fax: 800-736-1611

Section I: Patient Information
(TO BE COMPLETED BY PATIENT. ALL BOXES ARE REQUIRED EXCEPT WHERE NOTED).

Patient Name: Ashley Williams

Social Security Number *(Providing SSN is optional)*: 543217 6543

Date of Birth: 08/03/1973

Gender: ☑ Female ☐ Male

Patient Address *(no PO Boxes)*:

City: London

State: OH

Zip: 53317

Home Phone: 6153215432

Cell Phone *(optional)*: 6153215431

Email Address *(optional)*: ashley.williams@hotmail.c

Alternate Contact Name *(optional)*: Brian Williams

Relationship *(optional)*: Spouse

Phone *(optional)*: 615127 5432

Allergies *(you may attach a list on a separate page if more space is needed)*:

Allegra

All Current Medications *(you may attach a list on a separate page if more space is needed)*:

PATIENT INSURANCE INFORMATION – Do you have insurance through any of these providers?
(Check all that apply)

☑ Medicaid ☑ Medicare: ☐ Part A ☐ Part B ☑ Part D ☐ Part C/Medicare Advantage

☐ VA or Military ☐ Private Insurance ☐ None

☐ State Assistance Program for Medication ☑ Other: Cigna ABP

INSURANCE NAME	PHONE #	ID/POLICY #
Primary: Medicaid		
Secondary: Medicare Part D		
Prescription Coverage: *(Optional: Attach a copy of both sides of your prescription insurance card)*		ID/Policy #: 43758912
		RxBIN: / RxPCN:

Number of people living in your home:
*(Include yourself, your spouse, and any dependents **currently** living with you)*

TOTAL YEARLY HOUSEHOLD INCOME: $ 54,000

OR

TOTAL MONTHLY HOUSEHOLD INCOME: $ 5,000

Proof of income may be required: **Please provide your most recent federal tax return. If your federal tax return is not available, please provide as many of the following as available: W2, 1099, pension statement, Social Security statement, at least 2 consecutive pay stubs.**

Medicare Part D recipient: **If you have spent 3% of your annual income on out-of-pocket prescription costs, please contact your pharmacy to provide you with a report to document your yearly out-of-pocket expenses. Report must be attached to this application.**

Please continue to the next page to read, sign, and date the Patient Agreement & Consent.