Patient Assistance Re-Enrollment Form

NORD® National Organization for Rare Disorders

Patient Name: Address: Email: NORD Patient ID: Date of Birth:

Make corrections/additions/changes to contact information here:

Mailing Address	
Email:	
Home Phone:	
Cell Phone:	
Work Phone:	
Other:	

Program Applying To:

Please complete the following, (front & back)**,** and **return to NORD by December 6, 2019**

☐ I do not require assistance from the above referenced program for 2020 (return this form to address below)

☐ Yes, I am re-applying to the above referenced program for the 2020 calendar year.

If yes, complete form and return to **NORD Patient Assistance Re-Enrollment, 55 Kenosia Avenue, Danbury, CT 06810**

Yes	No	
☐	☐	NORD may leave a detailed message at the following numbers: Home: Mobile: Work:
☐	☐	NORD may email me regarding my participation in a Patient Assistance Program and to provide NORD related information.
Prescribing/Treating Physician: Name: Phone Fax		
Pharmacy Providing Medications for which NORD is assisting: Name: Phone Fax		

Current Insurance Benefits Information **Provide a copy of all current insurance cards (front & back).**

Plan Type(s): ☐ Medicare A or B ☐ Medicare Part D ☐ Medicaid ☐ State Aid ☐ Prescription Drug Plan ☐ COBRA ☐ Employer Sponsored ☐ Private/Marketplace ☐ Medicare Advantage ☐ Supplemental

Plan Premium Covers: ☐ Spouse ☐ Family ☐ Dental ☐ Vision ☐ Prescription Drugs

Primary Insurance Carrier: Secondary Insurance Carrier:

Yearly Coverage

Deductible	**Monthly Premium**	**Copay**	**Coinsurance**	**Out of Pocket Maximum**
$	**$**	**$**	**$**	**$**

Financially Responsible Party: Self ☐ Other: ☐ (If other, provide information below)

Name:	Address:		
Date of Birth:	Phone:	Relationship to Patient:	
Annual Household Income as reported on most recent Federal Tax Return:		$	# in household:
Was the patient listed as a dependent on the Financially Responsible Party's most recent Federal Income Tax Return: ☐ Yes ☐ No			

Complete and return Application, signed Disclosure, HIPAA Authorization, Copy of Insurance Card(s)

Disclosures

Identity

I, the undersigned, am the patient, the patient's parent or guardian, or otherwise legally authorized representative able to act on behalf of the patient.

Application

I certify that, to the best of my knowledge, all of the information provided in the application is complete and correct. I recognize that providing incomplete, inaccurate, or fraudulent information is grounds for revocation of my award.

Furthermore, I certify that I will notify the National Organization for Rare Disorders (hereafter referred to as NORD) of any changes to my treatment, diagnosis, or financial status.

I authorize my insurance company, prescribing physician, pharmacy, and/or listed contact person(s) to release to NORD any information that is needed or necessary to maintain my eligibility in the program. I authorize NORD to contact these entities to seek this information. I recognize that this information will be kept confidential and used for no other purpose than the enrollment process.

Withdrawal

I am aware that I may call NORD at any time at (800) 999-6673 to withdraw my application and revoke my permission to use my information.

Awards

I recognize that any award I may receive is subject to continued funding availability and financial need. I understand that NORD may withdraw my award or refuse payments for any reason at its discretion, with or without notice.

Medicare

I recognize that any medical expenses paid by NORD and any services rendered by NORD may not be counted toward my Medicare True Out-of-Pocket (TROOP) expenditures.

Medication

I understand that NORD assumes no liability for the safety or efficacy of my medication or prescribed treatments. I agree to hold NORD harmless from any and all claims resulting from the use of my medication or treatments.

_____ _____

Patient Name Date

_____ _____

Signature (Patient or Parent/Guardian) Print Name

Relationship to Patient: ☐ Self ☐ Parent/Guardian

HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act ---- 45 CFR Parts 160 and 164)

I _____ hereby authorize The National Organization for Rare Disorders
(PRINT PATIENT NAME)

("NORD") to use and/or disclose my Protected Health Information (''PHI'') described below:

I hereby authorize the release of PHI as follows **(check one)**:

___a. My complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS and treatment of alcohol/drug abuse).

OR

___b. My complete health record with the exception of the following information (check as appropriate):

___ Mental health records
___ Communicable diseases (including HIV and AIDS)
___ Alcohol/drug abuse treatment
___ Other (please specify): _____

In addition to the authorization for release of my PHI described above, I authorize the release or disclosure of any information or PHI in connection with any claim or appeal for coverage or benefits, including but not limited to benefits, premiums, eligibility, deductibles, claims payment, etc.

I hereby authorize NORD to discuss and receive copies of my PHI (e.g., explanation of benefits, etc.) as necessary to determine eligibility for assistance through the NORD Patient Assistance Program.

This authorization shall be in force and effect until nine (9) months after my death or _____, (date or event) at which time this authorization expires.

I understand that:

- I have the right to revoke this authorization, in writing, at any time;
- This revocation is not effective if a person or entity has already acted in reliance on my authorization or if an insurer relied on this authorization to provide coverage;
- Information used or disclosed pursuant to this Authorization may be disclosed by the Authorized Person(s) and may thus not be subject to federal/state privacy laws.

_____ Date: _____
Signature of Patient

_____ Date: _____
Signature of Parent/Guardian