

6900 College Boulevard, Suite 1000 Overland Park, KS 66211 phone 1-866-472-8663 fax 1-877-366-0585 email Lilly.PatOne@AccessMED.com

Check the box below that applies, complete and fax to 1-877-366-0585:

[] Patient Assistance Program (Uninsured Patients)

PATIENT INFORMATION: (Please print or type)

Form fields for Patient Information including Patient Name, Gender, SSN, DOB, Address, City, State, ZIP, Monthly Out of Pocket Medical Expenses, # in Household, and Monthly Gross Household Income.

PHYSICIAN INFORMATION: (Please print or type)

Form fields for Physician Information including Physician Name, Facility Name, NPI #, Address, City, State, ZIP, Contact Name, Phone # / EXT #, and Fax #.

DRUG REQUESTED :

On behalf of my patient, I request assistance for the Lilly drug specified in this application. I certify that I have obtained from my patient all required authorization for the release to Eli Lilly and Company and its representatives and agents of: 1) my patient's identification and insurance information, and 2) any additional medical or patient information needed for purposes of securing assistance under these programs.

Original Signature of PHYSICIAN _____ Date _____

I attest that the information supplied by me herein is complete and accurate. I authorize the release of the information contained herein. I understand it is for the sole use of Eli Lilly and Company, its representatives, and/or agents selected in order to assess my eligibility for participation in these Programs and to appeal denied claims on my behalf.

Original Signature of PATIENT or Legal Guardian _____ Date _____

[] Denied Claim Appeals Program (Insured Patients)

INSURANCE INFORMATION:

** Please provide copies of all insurance cards (front/ back) **

Does the patient have Medicare Coverage: [] YES [] NO

If Medicare, check all that apply: [] Part A [] Part B [] Part D

Medicare Policy # : _____ Effective Date: _____

If has Part D, list Prescription Drug Plan information below

Insurance Name: _____

Telephone: _____

Policy ID Number: _____

Private Primary Insurance: [] YES [] NO

Insurance Name: _____

Telephone: _____

Policy ID Number: _____

Secondary Insurance: [] YES [] NO

Insurance Name: _____

Telephone: _____

Policy ID Number: _____

Veterans/Medicaid/Other Insurance: [] YES [] NO

Insurance Name: _____

Telephone: _____

Policy ID Number: _____

PLEASE PROVIDE A COPY OF INSURANCE CARDS (Front and Back)