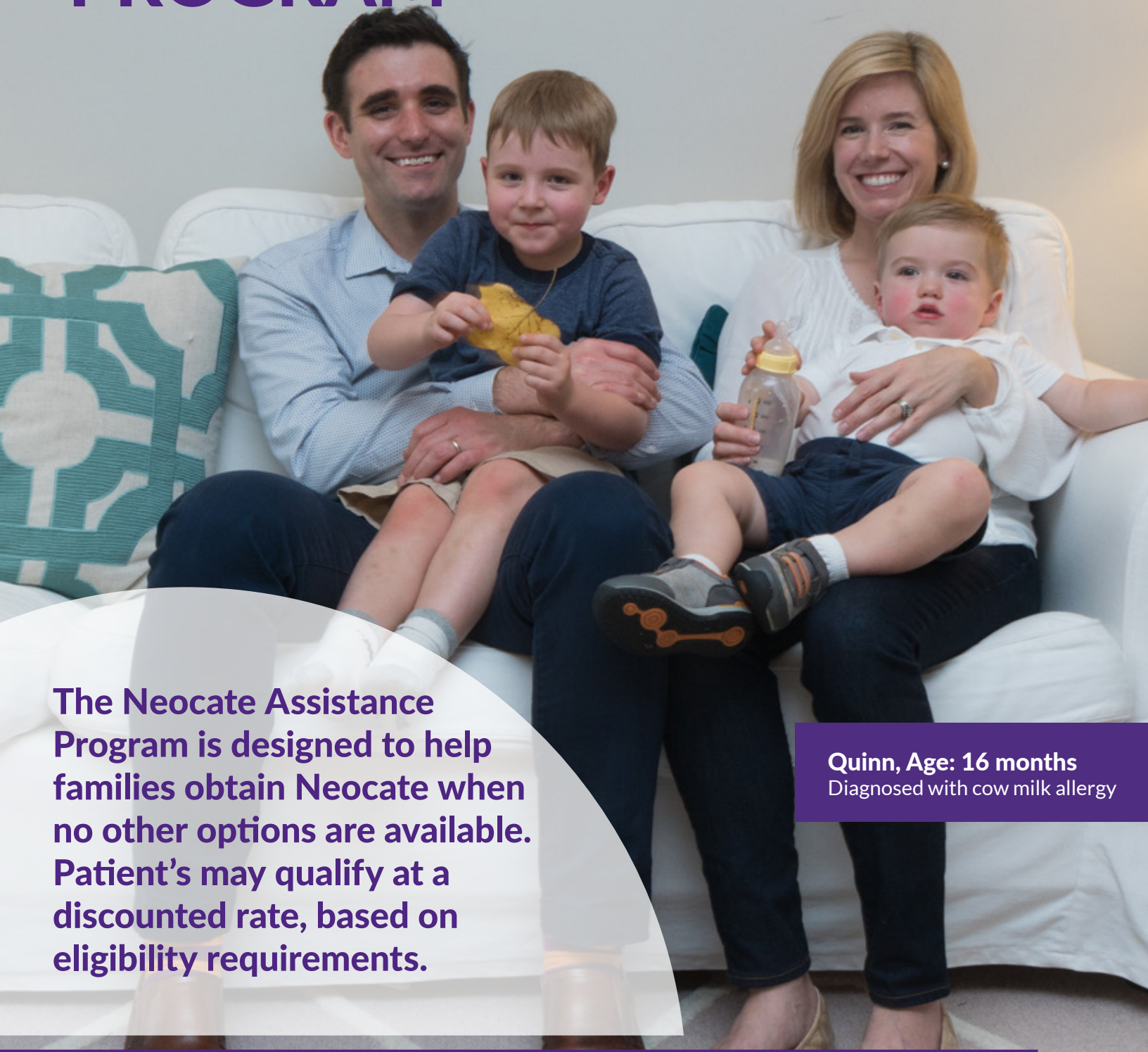
THE NEOCATE® ASSISTANCE PROGRAM

NUTRICIA Neocate®



The Neocate Assistance Program is designed to help families obtain Neocate when no other options are available. Patient's may qualify at a discounted rate, based on eligibility requirements.

Quinn, Age: 16 months
Diagnosed with cow milk allergy

NUTRICIA Advanced Medical Nutrition

Questions or comments about the Neocate Assistance Program?
Call 1-800-365-7354

The Neocate® Assistance Program

This application is for patients who would like to apply for the Neocate Assistance Program. The Neocate Assistance Program is designed to assist families facing financial hardship with obtaining Neocate at a discounted rate, if they meet program eligibility requirements. All applications are reviewed on a case-by-case basis in accordance with program criteria.

Do I qualify for Neocate Assistance?

To qualify for assistance, you must:

- ☐ Be a resident of the United States
- ☐ Not have third party coverage for nutritional therapy or have been denied coverage for Neocate
- ☐ Meet certain income limits as determined by Nutricia

Part 1: Patient Information – to be completed by patient or caregiver

How can I apply?

Be sure to include the following documentation when submitting your application:

- ☐ **Complete Parts 1 and 2, including required signatures**
- ☐ **Ask your physician's office to complete Part 3**

Provide a copy of the following documentation:

- ☐ Proof of income, such as previous year's federal tax return, OR W2, OR current pay stub, and Social Security Benefit Letter (if applicable), for all members of the household
- ☐ WIC, Medicaid and/or Social Security denial letter or copy of Medicare QMB/SLMB statement and Medicare card (if applicable)
- ☐ The denial letter from your insurance company
- ☐ Fax, email or mail the completed application and all documentation

Fax: 1-877-777-0164

Email: NutriciaNavigator@Nutricia.com

Address: Neocate Assistance Program
12862 Garden Grove Boulevard, Suite 240
Garden Grove, CA 92843

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The Neocate® Assistance Program

FOR NUTRICIA USE ONLY
Request #:

A. APPLICANT INFORMATION - PART 1 OF THE APPLICATION MUST BE ATTESTED TO BY THE APPLICANT OR APPLICANT'S REPRESENTATIVE. PATIENTS IN HEALTH CARE INSTITUTIONS ARE NOT ELIGIBLE. APPLICANT MUST HAVE VALID SOCIAL SECURITY NUMBER TO PARTICIPATE.

Patient Information

First Name: Last Name:

Last 4 digits of SS#: Date of Birth: Gender: ❑ M ❑ F

Guardian Name (if applicable):

Patient Address:

City: State: Zip:

Email: Phone:

B. FINANCIAL INFORMATION – ATTACH THE MOST CURRENT COPIES OF THE INCOME DOCUMENTS FOR YOU AND ALL MEMBERS OF THE HOUSEHOLD. SEE THE CHECKLIST FOR LIST OF REQUIRED DOCUMENTS. DO NOT SEND ORIGINALS.

Number of people in household including yourself: Number of children in household under age 18:

Monthly Gross Salary/Wages for all in household $

Social Security $ Interest/Dividends $

Disability $ Pension $ Child support/Alimony $

Unemployment $ Total All Sources $

C. HEALTH BENEFIT INFORMATION

Does Applicant have Medicare? ❑ Yes ❑ No
If yes, is it: ❑ Part A ❑ Part B
Does the Part B benefit provide coverage for the requested product(s)? ❑ Yes ❑ No
Attach a copy of Applicant's Medicare card

Has Applicant applied for financial assistance (Medicaid, SSI, etc)? ❑ Yes ❑ No
If yes, has the Applicant been denied assistance? ❑ Yes ❑ No ❑ Pending ❑ QMB ❑ SLMB
If yes, provide copy of denial within 2 years.
Does Applicant have Medicaid coverage for nutritional therapy? ❑ Yes ❑ No
If no, provide a copy of denial letter OR published policy stating the Neocate Product requested is not covered.
Is the Applicant eligible for food stamps? ❑ Yes ❑ No

Does Applicant have benefits through other state/government program (i.e., WIC, ADAP)?
❑ Yes ❑ No ❑ Not applied ❑ Application Pending ❑ Waitlisted ❑ Accepted ❑ Denied
If yes, does the benefit provide (partial or full) coverage for the requested products(s)? ❑ Yes ❑ No
Plan Name: Amount Provided:

Does Applicant have benefits through private insurance/HMO? ❑ Yes ❑ No
If yes, does it provide (partial or full) coverage for the requested product(s)? ❑ Yes ❑ No
Plan Name: Amount Provided:
If no, provide a copy of denial letter stating Neocate is not covered.

D. REPRESENTATIVE FOR PURPOSE OF PROGRAM

I permit the Neocate Assistance Program staff to speak with the following person(s) about my application and/or care and sign any documents related to the program on my behalf.

Name: Relationship:

Name: Relationship:

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Part 2: Authorization for Release of Health Information

This Authorization allows my healthcare providers and my durable medical equipment or pharmaceutical suppliers (together, "healthcare providers") and health plans to disclose to Nutricia North America, Inc. and its third party contractors, agents, and assignees (together, "Nutricia") protected health information ("PHI") about me related to my use or need for the products covered by Nutricia's Neocate Assistance Program. My PHI will include spoken or written facts, copies of my medical or other records from my healthcare provider or health plan outlining my medical history or treatment/management plan as well as my insurance benefits and coverage information. The purpose of the disclosure and use set out above is to allow Nutricia to (1) receive information from my healthcare providers and health plans about me to assess whether I qualify to participate in Nutricia's Neocate Assistance Program, and (2) contact my healthcare providers, health plan, insurance provider or other funding source to obtain information needed to determine whether I qualify for the Neocate Assistance Program or to determine if I am eligible for health insurance coverage or other funds, and disclose to them information contained in my Neocate Assistance Program application or other relevant PHI provided to Nutricia, and (3) contact me about Nutricia's Neocate Assistance Program.

I understand that: (1) Once my PHI has been disclosed to Nutricia it may no longer be protected by federal privacy law and may be re-disclosed by Nutricia as a result. (2) I can refuse to sign this Authorization without impacting the start, continuation, or quality of my treatment, payment for treatment, clinic or insurance enrollment, or eligibility for insurance benefits or coverage because my healthcare provider and/or health plan cannot condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization, but I will not be able to be considered for Nutricia's Neocate Assistance Program. (3) I may revoke, cancel or withdraw this Authorization at any time and for any reason by sending a signed written letter to Nutricia at the following address: 12862 Garden Grove Boulevard, Suite 240, Garden Grove, CA 92843. (4) If I cancel this Authorization, such cancellation will not change any actions that Nutricia or others took in reliance upon this Authorization before the date that I cancelled this Authorization. (5) This authorization expires when my consideration for or participation in the Neocate Assistance Program ends. (6) I have the right to receive a copy of this form from Nutricia.

Applicant's Signature: Date:

Applicant's Representative: Relationship to Applicant:

Part 3: Information from Physician – to be completed by physician

A. PHYSICIAN INFORMATION

State License #: DEA #:

Last Name: First Name:

Professional Designation:

Primary Specialty: Gender: ❑ M ❑ F

Office Mailing Address:

City: State: Zip:

Office Contact:

Phone: Fax:

B. NUTRITIONAL THERAPY INFORMATION

Product Name: Flavor:

Amount Needed Per Day: ❑ Ounces ❑ Grams ❑ Calories ❑ Cans ❑ Case(s) (check one)

_____% of Daily Caloric Intake Needs Administration: ❑ Oral ❑ Tube

Please provide a primary diagnosis that requires the need for nutritional therapy.

Primary Diagnosis:

C. CERTIFICATIONS:

Primary/Care Coordinator Verification: By my signature below, I confirm that (1) the patient indicated in this application has a valid medical need for the recommended product, (2) to the best of my knowledge, the patient does not have insurance coverage for the recommended product, (3) I have not been prohibited from participating in Federally-funded health care programs and I am not an excluded provider, (4) To the best of my knowledge, applicant''s acceptance into the Neocate Assistance Program is not in exchange for anything of value, and (5) I shall not seek reimbursement for any products received under the Neocate Assistance Program.

Physician's Signature: Date:

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