Phone: 1-888-53-STAR7 (888-537-8277)
www.AcrotechPatientAccess.com

Patient Enrollment Form

Requested Service:
- ❑ Verification of Insurance Benefits/Drug Coverage
- ❑ Apply for STAR Patient Assistance Program (PAP) if uninsured
- ❑ Apply for Co-Pay Assistance (for privately-insured patients only)
- ❑ Denied/Underpaid Claims Assistance

***NY PATIENTS:** Please attach a prescription written on an Official New York State Prescription pad.

PATIENT INFORMATION

First Name:	Last Name:	
Street Address:		
City:	State:	Zip Code:
Telephone:	Date of Birth:	
Gross Annual Household Income: $	Is the patient a U.S. Citizen or legal U.S. resident? ❑ YES ❑ NO	

INSURANCE INFORMATION

PLEASE PROVIDE LEGIBLE COPIES (FRONT AND BACK) OF ALL MEDICAL AND PHARMACY INSURANCE CARDS

Medical Company
Health and Services
OPEN OPTION
Signature Network
(Includes national)
Name: John Smith
ID Number: 024554879640012
Group Number: 79640012
Pharmacists: call 1-888-445-5518 for assistance
BIN # 908234 PCN # 0238562

This is NOT a real medical card, for placement only.
Send claims to: Medical Company
P.O.Box 1234, New York, NY 97208-3125
For customer service, please call:
503-574-6520 or 1-800-700-0481
For questions regarding Mental Health or Chemical Dependency services, please call 1-800-711-4577
MultiPlan/PHCS outside OR/WA/AK/N.ID/MT at 1-888-903-7427
For prior authorization and patient admissions, contact Medical Company at 1-800-444-4444.
Possession of this card does not in itself guarantee plan benefits.
PIN

Does the patient have insurance? ❑ YES ❑ NO

PHYSICIAN INFORMATION

Referring Physician Name:	Tax ID #:	NPI:
Facility Name:	Street Address:	
City:	State:	Zip:
Office Contact:	Phone:	Fax:

Treating Physician Name:	Tax ID #:	NPI:
Facility Name:	Street Address:	
City:	State:	Zip:
Office Contact:	Phone:	Fax:

MEDICATION AND PRESCRIPTION INFORMATION

Prescription for Patient Above - Check applicable drug.

- ❑ BELEODAQ® (belinostat) for injection
- ❑ EVOMELA® (melphalan) for Injection
- ❑ FOLOTYN® (pralatrexate injection)
- ❑ HEMADY® (dexamethasone) tablets
- ❑ KHAPZORY™ (levoleucovorin) for injection

Dosage per treatment:

Frequency:

List planned/future outpatient dates of service for drug:

List Patient Diagnosis and ICD-10-CM code(s):

List Patient's Current Medication:

List any allergies:

Patient Authorization and Release to Collect, Use and Disclose Certain Information:

By signing below, I verify that the information provided is complete and accurate. Furthermore, I authorize the disclosure and use of my financial information, insurance information, medical information, including personally identifiable protected health information to and by the STAR program for the purpose of allowing the STAR program to provide me with reimbursement support services, patient assistance support, and/or copay-assistance, and to evaluate me for eligibility in the STAR program. I also authorize my physician(s), pharmacist(s), other healthcare providers, patient advocacy organizations, and insurance companies to disclose to the STAR program, and the companies that help administer the STAR program, information about my medical condition, treatments, financial information, insurance status, and protected health information for the purpose of providing STAR services and assistance. Once my information has been disclosed, I understand that federal privacy laws may no longer protect that information. Additionally, I understand that nonidentifiable information from all STAR participants may be summarized for statistical or other purposes, but my identity cannot be determined from this summary information. By signing below, and enrolling in STAR, I hereby (i) authorize any and all disclosures of my identifiable health/financial/insurance information as set forth in this paragraph, and (ii) consent to such disclosure. I understand I may revoke this authorization by giving written notice of my revocation to STAR at the address above. I understand my revocation of this authorization will not affect any action STAR took in reliance on this authorization before STAR received my written notice of revocation.

PATIENT SIGNATURE

Patient Name (Print):	
Patient Signature (Required):	**Date:**

PHYSICIAN SIGNATURE

Prescribing Physician Name (Print):	
Prescribing Physician Signature (Required):	**Date:**

If applicable, Legal Representative/Guardian (Print)	Legal Representative/Guardian (Signature)	Legal Representative/Guardian (Date)

Fax Completed Form to 1-866-930-1562 or mail it to PO Box 220551, Charlotte, NC 28222-0551