

Provider Information

Hospital/Clinic Name	
Provider Name	NPI Number
Ship to Address (incl. City, State, Zip)	

Contact Information

Primary Contact

Name	
Phone	Email

Materials Management (if applicable)

Name	
Phone	Email

Provider Certification

- I am willing to participate in a brief virtual training on the use and application of ProgenaMatrix prior to applying the Product clinically
- I understand that neither I, nor my facility, may charge any patient or any payor for the Products provided through the CaringAccess program
- I understand that product provided through the CaringAccess program may not be used to treat any patient who is not approved to participate in the program.
- I understand that ProgenaCare Global™ may require updates regarding applicants' medical condition in order to approve continued participation in the Program. I agree to notify the Program if I become aware of changes to an applicant's medical condition or insurance coverage which may affect that applicant's participation.
- I will obtain from applicants all required written authorizations for the release of personal identification and insurance information to ProgenaCare Global and its representatives for the purpose of evaluating initial and continuing eligibility for the Program and the operations of the Program.

Provider Certification (cont'd)

- I understand that application to the Program does not guarantee that assistance will be obtained
- I understand that ProgenaCare Global may change the terms and conditions of the CaringAccess program or cancel the program at any time
- All approvals required by our facility for the use of ProgenaMatrix as part of the CaringAccess program have been obtained

Provider Signature

Date

Please fax completed application to 833.845.1042

Questions? call 877.776.4362 ext. 5 or email caringaccess@progenacare.com

For internal use only

License Verified?	Yes	No
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Approved by

Date
