CARING ACCESS

Patient Application

Patient Information

Patient Name	Date of Birth
Address (incl. City, State, Zip)	
Type of Wound	Size & Duration of Wound:
Active Infection or Osteomyelitis? Yes No	Time Under Treatment by Current Provider:
Provider Name	Hospital/Clinic Name

Patient Certification

I am under the care of a licensed health care provider who has prescribed ProgenaMatrix® for my wound, but I am uninsured or underinsured and unable to afford this treatment. **Please check one applicable box:**

- I am uninsured and unable to pay for my ProgenaMatrix® treatment out of pocket
- I am enrolled in Medicaid, but not in Medicare, and my Medicaid program will not cover ProgenaMatrix®
- I have private insurance on Medicare (Traditional or Advantage), but my insurance carrier will not cover ProgenaMatrix® or another suitable skin substitute product
- I have private insurance or Medicare but I am unable to pay for the deductible, coinsurance or copay required for my ProgenaMatrix® treatment

Please check one applicable box:

- I live in a household with a total household income less than $75,000
- I live in a household with more than four people and a total household income less than $100,000

I understand that following my health care provider's treatment plan and instructions, including but not limited to compression, offloading, nutrition and appointment follow-ups is critical to successful wound healing. I agree to follow my provider's instructions to the best of my ability during my participation in this program.

I understand that ProgenaCare Global™ may change the terms and conditions of the CaringAccess™ Patient Assistance Program or may cancel the Program at any time.

I understand that I or my provider may need to provide personal information, insurance information, and medical information regarding my care to evaluate my eligibility for the Program. By signing this CaringAccess™ Patient Assistance Program Application, I authorize the release of medical and other patient information to agents and service providers of ProgenaCare Global™ to use and disclose as necessary for verification of my eligibility and the operations of the Program.

Patient Signature

Date

PROVIDER CERTIFICATION ON NEXT PAGE

progenacare

CARING ACCESS

Patient Application

(v)

Provider Certification

- This patient is currently under my care, and the medical information in this application is correct to the best of my knowledge
- I believe the use of ProgenaMatrix® is medically appropriate for the treatment of the patient, and consistent with the product label and indications.
- I will supervise the care of the patient, including the application of any ProgenaMatrix® provided under this Program
- I understand that neither I nor my facility may charge the applicant or any other patient or payor for the Product provided through the CaringAccess™ program
- I understand that ProgenaCare Global™ may require updates regarding the applicant's medical condition in order to approve continued participation in the Program. I agree to notify the Program if I become aware of changes to the applicant's medical condition or insurance coverage which may affect the applicant's participation.
- I have obtained from the applicant all required written authorizations for the release of personal, insurance and medical information to ProgenaCare Global™ and its representatives for the purpose of evaluating continuing eligibility for the Program.

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

Approved by
Date

progenacare