Patient Assistance Program Request Form

Instructions for Submitting Requests

This document must be completed by the Healthcare Provider responsible for prescribing the MIMEDX product & patient.

Please note that submitting this request does not guarantee that the request will be approved.

Once complete, all four pages of the request form should be faxed to 1-770-590-3552. To securely transmit Protected Health Information (PHI), only use the fax number provided to send the completed forms. Do not use unencrypted email to send PHI.

All forms that are incomplete when submitted will be rejected.

Ship To:
Prescriber Name:
Contact Name:
Phone:
Fax Number:
Prescriber NPI or license # (required):
Business Name:
Facility Type:
Address:
City, State, Zip:

REASON FOR REQUEST

This page should be completed by the patient's healthcare provider.

Is the patient insured? □ Yes □ No

- **Program is for uninsured patients only**

Is the patient a U.S. resident □ Yes □ No

- **Program is for patients who are United States citizens or a lawful permanent resident in the United States and/or Puerto Rico only**

Is the patient diagnosis for a Diabetic Foot Ulcer (DFU) or a Venous Leg Ulcer (VLU)? □ Yes □ No

- **Product will only be supplied for the above diagnoses**

Has the provider or patient requested alternative funding resources? □ Yes □ No If yes, please specify what type & results of the request.

_____

_____

Is the patient's income below 250% of the U.S. Department of Health and Human Services Poverty Guidelines (see chart below)? □ Yes □ No

Household Size	250% of Federal Poverty Guideline Total Household Income
1	$39,125.00
2	$52,875.00
3	$66,625.00
4	$80,375.00
5	$94,125.00

Product Requested – Only EPIFIX or EPICORD available	**Quantity**	**Intended Use of MIMEDX Product** *Please provide detailed information about why this specific product and requested quantity is necessary for the treatment of the patient in question. (i.e., wound size and anticipated number of treatments)*

Legal Terms & Conditions:

The MMEDX Patient Assistance Program is a charitable product donation program for individual patients. Products donated via the MIMEDX Patient Assistance Program impose no obligation, express or implied, for healthcare professionals or practices to purchase MIMEDX products. By signing below, the prescriber is requesting the above listed product donations for charitable purposes and confirms the information above is accurate and complete. All requests are subject to MIMEDX review and approval.

I certify, on behalf of myself and my practice, that I will not seek payment or accept reimbursement for any products supplied via the MIMEDX Patient Assistance Program from any patient or third-party payer, including but not limited to, Medicare, Medicaid, other government entities or commercial insurance plans.

I confirm that it is my medical judgment that the product requested is medically reasonable and necessary for treatment of this patient.

I certify that I have received the necessary patient authorization to release the medical and/or patient information to MIMEDX for purposes of verifying eligibility for the MIMEDX Patient Assistance Program. To the best of my knowledge, the information provided is complete and accurate.

If MIMEDX Patient Assistance Program products are NOT used for the treatment of the patient indicated on the request form, the physician and practice will notify MIMEDX and immediately return such unused product to MIMEDX.

Prescriber Signature: _____ Date: _____

Print Prescriber Name: _____

Prescriber Specialty: _____

Prescriber NPI/License Number: _____

PATIENT ACKNOWLEDGEMENT

This page should be completed by the patient or a representative on their behalf

I certify that my income level falls below 250% of the U.S. Department of Health and Human Services Poverty Guidelines based on my household size, as indicated on the chart below? ☐ Yes ☐ No

Household Size	250% of Federal Poverty Guideline Total Household Income
1	$39,125.00
2	$52,875.00
3	$66,625.00
4	$80,375.00
5	$94,125.00

Patient Name: _____

Address: _____

City/State/Zip code: _____

Date of Birth: _____

Gender: _____

U.S. Citizen or lawful permanent resident in the United States and/or Puerto Rico: ☐ Yes ☐ No

By signing below, I hereby confirm that my Total Household Income falls below 250% of the Federal Poverty Guidelines as indicated in the chart above. I further acknowledge that I may be asked to provide to MIMEDX my tax return or other income information in order for MIMEDX to verify my income and eligibility for this request, and that failure to provide such information will disqualify my eligibility. Additionally, I confirm that I am not covered by any commercial or government insurance plan at this time. MIMEDX may request, review and confirm my insurance coverage as part of determining my eligibility for the MIMEDX Patient Assistance Program.

Patient Signature: _____

Date: _____

Email: _____