

**WellSpring Pharmaceutical Patient Assistance Program**

**P.O. Box 801  
Somerville, NJ 08876  
(908) 203-3791**

- 1. Original application must be completed in its ENTIRETY.**
  - 2. Practitioner must sign and date application.**
  - 3. Attach original prescription (signed by prescribing Practitioner) for a 3 month supply.**
  - 4. Patient or authorized representative must sign and date completed application and HIPAA release form.**
  - 5. Required supporting documentation includes:**
    - \* Proof of ALL household income (most recent federal tax return 1040, Social Security SSA 1099, pensions, interest, etc.). If you do not file a federal tax return, please call 1-908-203-3791 for instructions.
    - \* Dated letter from Medicaid verifying current coverage.
    - \* The patient must submit a signed letter stating the patient has no prescription coverage.
    - \* Copy of insurance card(s) (Private, Medicare, Supplemental and/or Medicaid)
    - \* Provide a written statement from the patient's insurance company, private or supplemental, and/or Medicaid office stating the patient has no prescription coverage (if applicable).
- \* Application, HIPAA release form, prescription and required documentation must be mailed to the above address.**
- \* If patient is approved for the program, product will be shipped directly to the office of Practitioner.**
- \* Any questions, please call 1-908-203-3791.**

APPLICATION FORM  
**WellSpring Pharmaceutical**  
**Patient Assistance Program**  
P.O. Box 801, Somerville, NJ 08876  
(908) 203-3791

**PATIENT SECTION (To be completed by the patient or authorized signing representative)**

<b>Patient Instructions</b>	
1. Make sure the physician section is signed by the physician.	4. Attach copy of proof of denial letter if appropriate.
2. Complete the eligibility section.	5. Read, sign and date the patient verification section.
3. Attach copy of most recent federal tax return. If patient does not file, call (908) 203-3791 for additional instructions.	6. Call 1-908-203-3791 for further case management.
	7. <b>DO NOT MAIL FORM</b> prior to calling.

**1) Patient Information**

Name _____	SSN _____
Address _____	DOB _____
_____	Phone _____
Diagnosis _____	Diagnosis Code _____

**2) Eligibility**

A. Gross annual household income from most recent federal tax return, including social security, pension benefits, etc. \$ \_\_\_\_\_

B. Number of dependents in household (including self) \_\_\_\_\_

C. Healthcare	Yes	No	Is the patient covered or eligible for any type of health coverage, including but not limited to private insurance, Medicaid, Medicare, VA state and local plans? Yes No
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Medicaid.	Yes	No	Private Insurance/HMOs.. Yes No
Medicare	Yes	No	Private foundations Yes No
Other federal (e.g. Veterans Administration)	Yes	No	Other..... Yes No If yes, please specify
Other State/local government program	Yes	No	_____

**3) Patient Verification**

I verify that the information provided in this application is complete and accurate. I further understand that reported financial and insurance information may be verified by an audit as deemed necessary by the program. I understand that WellSpring Pharmaceutical reserves the right at any time and without notice to modify the application form or modify or discontinue any or all programs and the related eligibility criteria.

Patient or Authorized Representative Signature _____	Date _____
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**PHYSICIAN SECTION (To be completed by the physician)**

<b>Physician Section</b>	
1. Read, sign and date the physician certification section.	2. Give the application and prescription to the patient and have them call 1-908-203-3791 for further case management.

**1) Physician Information**

Name _____	Phone _____
Address _____	Fax# _____
_____	DEA# _____

**2) Physician Certification**

My signature certifies that goods received from WellSpring Pharmaceutical is for the use of the above named patient only. These goods will not be resold nor offered for sale, trade or barter and will not be returned for credit. WellSpring Pharmaceutical reserves the right to recall the product when necessary. Additionally, to the best of my knowledge, the above named patient meets the criteria for patient assistance.

Original Signature of Physician _____	Date _____
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**ATTACH ORIGINAL SIGNED PRESCRIPTION**

7/14/2009



WellSpring Pharmaceutical Corporation

Health Insurance Portability and Accountability Act (HIPAA) compliance:

By signing the authorization below, you agree to:

I authorize WellSpring Pharmaceutical and their authorized agent(s) to use the information on the application to process my request for medication from the WellSpring Patient Assistance Program and authorize the use of my Social Security number for identification purposes and record keeping. I further authorize WellSpring to use the information contained on this form to contact me or my healthcare provider to review my eligibility for the program, and to confirm receipt of medications. I agree that I will contact the WellSpring Patient Assistance Program if any of the information regarding prescription drug coverage or insurance changes. I understand that I may revoke this consent and withdraw from participation in the program at any time by calling (908) 203-3791. I understand that my prescribing physician is responsible for choosing which prescription products are right for me, and that WellSpring is not responsible for verifying my medical condition or my prescribing physician's selection of products.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_