

PATIENT APPLICATION

	Please chec	k one of the following bo	xes*: 🗌 la	am a new patient	☐ lamre-e	enrolling	
1 Patient Informa	ation						*=REQUIRED FIELDS
First Name*		 Last Name*		Email			
Date of Birth (MM/DD/YYYY)*		_ Sex for Clinical Use * : ☐ Male ☐ Female		Mobile Number*—We'll keep you updated through non-marketing calls/texts.†			
Address (No PO Box	×)*		Home Number*— We'll keep you updated through non-marketing calls/texts.†				
City*		State*	ZIP*	ZIP* Reside in the U.S. or Territory*: Yes			ory*: Yes No
I give permission to d	lisclose my personal	health information to the follo	wing caregiver:				
Caregiver Name		Relationsh		p to Patient	Phone Number		
2 Insurance Info	rmation						
To prevent delays, pl	ease include copies	(front and back) of <u>all</u> insura	<mark>nce card(s).</mark> This	includes primary, s	econdary, and p	rescription ir	nsurance.
Plan Type		Plan Name		ID#	Phone#		
Medicare (Red/White/Blue Card)							
Medicare Part D/Advantage							
Medicare Suppler	mental/Other						
Medicaid/Tricare/VA/DoD							
Private Insurance							
	ou have insurance thiption drug coverage	nrough an employer):	,		,		
		that you provide your proof o		•			
4 Patient Author I have read and ag		ithorization on page 2.					
Patient/Legal Gu	ardian Signature*					Date	(MM/DD/YYYY)

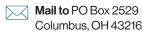
Complete the entire form and fax to NPAF at 1-855-817-2711 or mail to: NPAF, PO Box 2529, Columbus, OH 43216

An incomplete form will result in a processing delay or application denial.









Page 1 of 2 8/23