



## Abbott Patient Assistance Foundation's Application for Medical Nutrition Products

The Abbott Patient Assistance Foundation provides Abbott Medical Nutrition Products at no cost to patients experiencing financial difficulties. Eligible patients typically have no healthcare coverage for the requested product and do not have access to alternative sources of coverage or funding. All applications are reviewed on a case-by-case basis to support the Abbott Patient Assistance Foundation's purpose of providing products at no cost to individuals in need.

**The Abbott Patient Assistance Foundation's Medical Nutrition Products Patient Assistance Program is designed to supplement medical nutrition product needs.**

**Abbott Nutrition Products available through the Foundation do not include all packaging configurations and flavors.**

**If the product you or your health care professional has requested is not available, you will be provided with product that most closely meets the ingredient composition of the product specified in the initial request.**

### Checklist for submitting an application:

- Ensure all sections of the application are completed. Make a copy before sending as no documents will be returned.
- Attach current proof of income (tax return, W2, pay stub) for all in household.
- Patient's signature/date is required on the application.
- Prescriber's signature/date is required on the application.
- Provide copy of Medicaid and/or Social Security denial, if applicable.
- Provide copy of private insurance denial letter OR the published policy that states nutritional products are not a covered benefit, if applicable.

### Fax or mail the completed application and documentation to:

Abbott Patient Assistance Foundation  
PO Box 270  
Somerville, NJ 08876  
Fax: 866-483-1305  
Phone: 800-222-6885

Upon receipt of a completed application, the patient will be notified of program eligibility. The approved supply of product will be shipped to the patient's home unless otherwise specified. It is the responsibility of the prescriber's office or the patient to reorder. Reorders can be requested once every three months during an approved enrollment.

Please contact us at 1-800-222-6885 Mon-Fri 8am-5pm CST for additional assistance.



Medical Nutrition Products Patient Assistance Program Application
Abbott Patient Assistance Foundation • PO Box 270 • Somerville NJ 08876
Phone: (800) 222-6885 • Fax: (866) 483-1305

Applications are available by calling 1-800-222-6885 or visiting www.AbbottPatientAssistanceFoundation.org

PATIENT INFORMATION

Patient Name, Gender, Telephone Number, Patient Address, City, State, Zip, Date of Birth, SSN, Medicare enrollment, Private insurance coverage, Total Monthly Income, Patient's Signature, Date, Number of people in household.

Representative For Purposes of Program (If applicable)

I permit the Abbott Patient Assistance Foundation to speak with the following person(s) about my application and/or care and sign any documents related to the Program on my behalf
Name: Relationship: Phone:

Personal Representative Authorization (If applicable)

Note: If the Applicant is unable to sign, is under the age of 18, or has designated signature authority, the Applicant's Personal Representative may sign this Form. However, only certain individuals may qualify as the Applicant's Personal Representative for purposes of this Authorization.

Patient's Representative Signature: Relationship: Date:

Product Requested

If the product requested is not available, you will be provided with product that most closely meets the ingredient composition of the requested product.

Product, Flavor(s), Administration (Oral/Tube), % Caloric Need to be met with Product, Estimated Total Caloric Need of Patient (Daily), Number of servings per day.

Primary Diagnosis: Indications for Use:

Please provide both a primary diagnosis (i.e. HIV/Aids, diabetes, etc.) and the indications for use (i.e. involuntary weight loss, cachexia, malnutrition, etc.) that requires the need for nutrition therapy. Applications for Metabolic products and Elecare require a primary diagnosis only.

PRESCRIBER INFORMATION

Name and Professional Designation of Prescriber, DEA#, SLN Expiration Date, Shipping Address, City, State, Zip, Mailing Address, City, State, Zip, Office Contact Person, Telephone Number, Fax Number, Authorization for Release of Health Information, Physician/Care Coordinator Verification, Prescriber's Signature, Date.

Notice to Health Care Providers and Insurers: This form of authorization may not comply with all applicable Federal and state laws governing disclosure of the applicant's information to the Foundation and its contracted third parties.