**Make corrections/additions/changes to contact information here:**

|  |  |
| --- | --- |
| As of date: |  |
| Mailing Address |  | |
|  |  | |
| Email: |  | |
| Home Phone: |  | |
| Cell Phone: |  | |
| Work Phone: |  | |
| Other: |  | |

Re-Enrollment Form for 2018



Patient Name:

Address:

City: State: Zip:

Email:

NORD Patient ID:

Date of Birth:

Program Name:

**Please complete the following, sign the back, and return to NORD by December 1, 2017**

I do not require assistance from the above referenced program for 2018 (return this form to address below)

Yes, I am applying to the above referenced program for the 2018 calendar year.

If yes, complete form and return to **NORD Patient Assistance Re-Enrollment, 55 Kenosia Avenue, Danbury, CT 06810**

|  |  |  |
| --- | --- | --- |
| Yes | No |  |
|  |  | **My financial status has changed**, If yes, enclose the most recent 3 months bank statements from all accounts for all financially responsible members of your household |
|  |  | **My insurance information has changed**, If yes complete the Insurance Update section below – \* please provide 2018 benefits information below under Yearly Coverage. |
|  |  | **My prescribing/treating physician has changed**  If yes list name, phone & fax numbers here: |
|  |  | **My pharmacy has changed**  If yes list pharmacy name here: |
|  |  | **I wish to add, remove or change alternate contact information**  If yes, complete the Alternate Contact section |
|  |  | NORD may send text messages to my cell phone related to my participation in this program. |
|  |  | NORD may communicate with me using email as the preferred method |

**Change(s) to financial status:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Marital status has changed to: | married | single | separated | | widowed | divorced |
| Annual Household Income has changed to: | | $ | | # in household | | |
| **Award recipient has turned or will turn 18 on:** | | | | | | |

**Insurance Benefits Information, as of date:**

|  |
| --- |
| *Plan Type:*  Medicare A or B  Medicare Part D  Medicaid  via employer  private  COBRA  *Plan Category:*  Medicare Advantage  Supplemental (Medigap)  HSA  HMO  PPO  POS  **Insurance Co. Name:** |

**\* Yearly Coverage**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Deductible**  **$** | **Monthly Premium**  **$** | **Copay**  **$** | **Coinsurance**  **$** | **Out of Pocket Maximum**  **$** |

**Addition of, or change to, Alternate Contact Information:**

|  |  |
| --- | --- |
| Home Ph: | Cell Ph: |
| Relationship to Patient: | Is Primary Contact:  Yes  No |

Disclosures

# Identity

I, the undersigned, am the patient, the patient’s parent or guardian, or otherwise legally authorized representative able to act on behalf of the patient.

# Application

I certify that, to the best of my knowledge, all of the information provided in the application is complete and correct. I recognize that providing incomplete, inaccurate, or fraudulent information is grounds for revocation of my award.

Furthermore, I certify that I will notify the National Organization for Rare Disorders (hereafter referred to as NORD) of any changes to my treatment, diagnosis, or financial status.

I authorize my insurance company, prescribing physician, pharmacy, and/or listed contact person(s) to release to NORD any information that is needed or necessary to maintain my eligibility in the program. I authorize NORD to contact these entities to seek this information. I recognize that this information will be kept confidential and used for no other purpose than the enrollment process.

# Withdrawal

I am aware that I may call NORD at any time at (800) 999-6673 to withdraw my application and revoke my permission to use my information.

# Awards

I recognize that any award I may receive is subject to continued funding availability. I understand that NORD may withdraw my award or refuse payments for any reason at its discretion, with or without notice.

## Medicare

I recognize that any medical expenses paid by NORD and any services rendered by NORD may not be counted toward my Medicare True Out-of-Pocket (TROOP) expenditures.

# Medication

I understand that NORD assumes no liability for the safety or efficacy of my medication or prescribed treatments. I agree to hold NORD harmless from any and all claims resulting from the use of my medication or treatments.

|  |  |  |
| --- | --- | --- |
| Patient name | Name (if other than patient) | |
|  |  | |
| Signature *(when form is sent electronically your printed name indicates your intent to sign)* | Relationship to patient | Date |
|  |  |  |