Hannah Wernke Memorial Foundation
P.O. Box 361221
Strongsville, Ohio 44136

HannahWernkeMemorialFoundation.com

Patient Assistance Program for CPVT Genetic Testing
Enrollment Application
Patient Information

To apply for assistance from the Hannah Wernke Memorial Foundation, please complete each section to the fullest extent possible. If an item does not apply to your situation, please note "N/A" on that line. If you have any questions about this application or the application process, please call the Hannah Wernke Memorial Foundation at 440-725-9726.

Please be aware that completing this application does not guarantee the availability of assistance. The Hannah Wernke Memorial Foundation provides assistance based on eligibility criteria, availability of funding, and the terms and conditions that the Foundation establishes for awarding assistance. The Foundation will provide partial support for assistance, based on Foundation policies.

Section 1 – Patient Information

Applicant's name: _____ DOB: _____
(If patient is a minor, parent/guardian's name required here)

Address: _____ Daytime phone: _____
_____ Evening phone: _____
_____

Name of patient for CPVT testing: _____

Relationship to person applying: _____

Presenting symptoms: _____

Family history of sudden cardiac death? _____ yes _____ no

Will you be willing to share your test results with the Hannah Wernke Memorial Foundation? _____yes _____no
Will you be willing to complete a brief survey following completion of testing for project evaluation purposes? _____yes _____no

Section 2: Health Insurance Information:

Primary health insurance carrier: _____

Policy #: _____ Group #: _____

Subscriber's name: _____ Relationship to patient: _____

Subscriber's employer: _____

Subscriber's date of birth: _____ Insurance carrier's phone #: _____

Is there coverage for the FAMILION CPVT Test? ____ yes _____no

If yes, indicate the estimated remaining out-of-pocket cost: $_____

If no, do you authorize Hannah Wernke Memorial Foundation to petition your insurance carrier on your behalf ? ____ yes ____no

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Section 3 – Healthcare Provider Information

Referring physician's name: _____

Address (Hospital or clinic): _____
_____
_____

Section 4 – Required Documentation

Please submit a copy of the following information with your application:

1. Copies of both the front and back of your insurance card(s)

Section 5 – Applicant Declaration

I verify that the information provided in my application is complete and accurate. I further understand that reported financial information may be verified by an audit as deemed necessary by the Foundation. I understand that, if I am approved for assistance by the Foundation, assistance will terminate if the Foundation becomes aware of any fraudulent activity relating to my application or the assistance provided to me by the Foundation. I understand that any assistance the Foundation may provide is limited to the terms and conditions established by the Foundation and that the Foundation reserves the right at any time and for any reason, without notice, to (i) modify this application form, (ii) modify or discontinue any assistance provided by the Foundation or the Foundation's eligibility criteria, or (iii) terminate assistance.

I authorize the Foundation and it's employees, third party administrators, agents and other representatives to obtain health information from my health care providers, insurance coverage information from my employer or insurance companies and other information as necessary to complete this application process or verify the accuracy of any information provided with this application.

Signature of Applicant: _____ Date: _____

Return completed application and supporting documentation to:

The Hannah Wernke Memorial Foundation
PO Box 361221
Strongsville, Ohio 44136
E-mail: HWMF2008@roadrunner.com
Phone: 440-725-9726
Fax: 440-878-9135