Organogenesis Inc. LIVING TECHNOLOGY Circle of Care with you at every step

Patient Assistance Program (PAP) Application

Please complete form and fax to: 1.866.212.2888

The purpose of the Patient Assistance Program is to provide access to Apligraf,® Dermagraft,® PuraPly,™ and PuraPly™ AM at no charge for those most in need. The program may assist patients who have limited financial resources, and no public or private insurance coverage. Additional copies of this form are available on Apligraf.com and needymeds.org.

Physician Information:

Facility Name:_____ Facility Tax ID #:_____

Physician Name:_____ Office Contact:_____

Office Address:_____

City/State/Zip Code:_____

Phone #:_____ Fax #:_____

Patient Information:

Patient Name:_____ Date of Birth:_____

Social Security #:_____ U.S. Resident: ☐ Yes ☐ No

Address:_____

City/State/Zip Code:_____

Phone #:_____

If approved, date of procedure:_____ ☐ **Apligraf** ☐ **Dermagraft** ☐ **PuraPly** ☐ **PuraPly AM**

Primary Insurance:_____ Phone #:_____

ID #:_____ Group #:_____

Secondary Insurance:_____ Phone #:_____

ID #:_____ Group #:_____

Income Information *(a copy of the patient's 1040 tax form or Social Security Income Statement is required)*:

Annual Salary: $_____ Household Size:_____

Social Security: $_____ Savings Balance: $_____

Other Assets (Real Estate/Stocks/Bonds): $_____

Do you receive or have you applied for state assistance? ☐ Yes ☐ No

If Yes, please specify what type and when you applied:_____

I attest that the insurance and income information provided is complete and accurate. I consent to the release of confidential information, including the information on this form, by the physician for the purpose of determining eligibility under the Patient Assistance Program. I authorize the assigned Reimbursement Support Center Specialist to contact the insurance companies listed on this form with respect to determining eligibility under the Patient Assistance Program. My consent is for the initial application and also any subsequent applications beyond the initial application (up to 10 applications for PuraPly and PuraPly AM).

Patient Signature:_____ Date:_____

Physician Signature:_____ Date:_____

Apligraf® Dermagraft® PuraPly™ Wound Matrix PuraPly™ ANTIMICROBIAL Wound Matrix