Insurance Benefits Verification Form

This form enables EMD Serono Fertility Lifelines™ to investigate your insurance coverage for fertility treatment. Please complete steps 1, 2, 3 and 4. Please fax the completed form toll-free to 1-866-882-2900. If you have any questions, please feel free to contact us toll-free at 1-866-LETS-TRY (1-866-538-7879).

STEP 1: Patient Information

(To be completed by patient)

Patient Name	Social Security No.	Date of Birth	Sex ☐ Male ☐ Female
Home Address	City/State/Zip		
Home Phone	Work Phone	E-mail	
Preferred Phone: ☐ Home ☐ Work May we leave a message of you are not available? At home ☐ Yes ☐ No At work ☐ Yes ☐ No			
Physician Name	Physician Phone	Physician Fax	
Center Name	Center Address		
☐ Check here if you would like your results sent to your doctor.			

STEP 2: Patient Insurance Information

(To be completed by patient)

Please complete below and attach a copy of the front and back of your insurance card(s)

PRIMARY INSURANCE		**SECONDARY INSURANCE**	
Cardholder	ID No.	Cardholder	ID No.
Group No.	Phone	Group No.	Phone
Do you have a pharmacy benefit card? ☐ Yes ☐ No		Do you have a pharmacy benefit card? ☐ Yes ☐ No	
Name of Pharmacy Benefit Manager		Name of Pharmacy Benefit Manager	
ID No.	Group No. / Phone	ID No.	Group No. / Phone

STEP 3: Patient Consent

(To be completed by patient)

I understand that EMD Serono Fertility Lifelines™ will use reasonable care in its investigation of my insurance coverage and will endeavor to accurately report to me information it receives from third parties regarding my insurance coverage. However, I understand that EMD Serono Fertility Lifelines™ can not guarantee the accuracy of information it receives from third parties and that the results of EMD Serono Fertility Lifelines™ investigation may differ from my insurance company's ultimate determination of coverage. I understand that the services provided by EMD Serono that are described in this authorization can be changed at any time, without prior notification.

Please review and complete patient authorization on reverse side.

PATIENT'S SIGNATURE	**DATE**
X	

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STEP 4: Patient Authorization

(To be completed by patient)

Authorization to Use and Disclose Health and Other Personal Information

I authorize my physician and their staff to disclose my health and other personal information, including, but not limited to, the information on my completed Insurance Benefits Verification Form to EMD Serono, Inc. and its agents and representatives (collectively "EMD Serono") so that EMD Serono may use and further disclose my information to healthcare providers, pharmacies, insurance companies, prescription drug plans and other third-party payers (collectively, "Third Parties") in order to assist me in evaluating my insurance coverage for infertility treatments, including medication coverage.

I further authorize the Third Parties to disclose health and other personal information about me in their possession to EMD Serono in order to assist EMD Serono in accomplishing the purposes described above.

I understand that once my information is disclosed pursuant to this authorization, it may no longer be protected by federal privacy laws (the Health Insurance Portability and Accountability Act). However, I understand that EMD Serono will not release my information to any party, except as provided in this authorization or as permitted by applicable law, without first obtaining my (or my authorized representative's) separate written consent.

I understand that I may refuse to sign this authorization and such refusal will not affect my ability to receive EMD Serono Fertility Products, but it will limit EMD Serono's ability to investigate my coverage for fertility treatment.

I understand that this authorization will remain in effect for ten years from the date of my signature, unless I revoke it earlier by contacting EMD Serono in writing at One Technology Place, Rockland, MA 02370.

If I revoke this authorization, EMD Serono will stop using and disclosing my information as soon as possible, but the revocation will not affect prior use or disclosure of my information in reliance on this authorization.

I also understand that I have the right to receive a copy of this authorization.

_____

Patient Name (please print)

_____

Patient Signature

_____

Date