PATIENT SOLUTIONS ENROLLMENT FORM

Please fax this completed form to 888-608-0520 or email mbpatientsupport@rxtalents.com
You may also call us at 888-608-0698

For Wounds & Burns Keragel® Enriched With Bioactive Keratin
For Wounds & Burns KeragelT® Enriched With Bioactive Keratin
For Wounds & Burns Keramatrix® Enriched With Bioactive Keratin

PATIENT INFORMATION

First Name _____ Last Name _____ Middle Initial _____
Date of Birth ___/___/_____ Last 4 Digits of SSN_____ Male __Female__Other__
Street Address _____ Apt # _____
City _____ State_____ Zip Code _____
Cell Phone (___)_____ Other Phone (___)_____ Email Address_____
Preferred Method Phone ___ Email ___ Preferred Time Morning ___ Afternoon ___ Evening ___
Caregiver (If Applicable)_____
Patient's Primary Language English ___ Other _____

INSURANCE INFORMATION

Please Include Copies of All Available Insurances and Prescription Cards (Front and Back)
Primary Medical Insurance Name _____
Insurance Phone # _____ Policy ID # _____
Group # _____ Policy Holder Name (First and Last)_____
Employer _____ Relationship to Patient _____
Current Address _____ City _____ State _____
Prescription Drug Insurance Name (If Applicable) Zip _____
Insurance Phone # _____ Policy ID # _____
Group # _____ Rx BIN # _____
Rx PCN # _____

Secondary Medical Insurance Name
Insurance Phone # (___)_____ Policy ID # _____
Group # _____ Policyholder Name (First and Last)_____

Required for Keragel Financial Assistance Program for Uninsured or Underinsured Patients

Current Annual Gross Income $ _____ Number of Household Members Including Patient _____
(Please include before tax wages, pension, interest/dividends, social security benefits, and any other sources of income)

PRESCRIBER INFORMATION

Prescriber's Name _____ Facility Name _____
Prescriber DEA # _____
Prescriber NPI _____ Office Contact Name_____
Office Contact Email _____ Fax (___) _____
Address _____ Phone (___) _____
City _____ State _____ Zip_____

TREATMENT INFORMATION

Diagnosis:_____How long has wound been unhealed_____
What treatments have been tried?_____
Desired therapy (select one) ☐ Keragel ☐KeragelT ☐Keramatrix

MOLECULAR BIOLOGICALS

RXTALENTS Accelerate Your Innovation

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Patient Name _____ Date of Birth _____

AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION

By signing this Authorization to Release Health Information, I authorize my health care providers, pharmacies, health plans, and insurers (and contracted services) to disclose to Molecular Biologicals and its third party business partners information about my insurance coverage, diagnosis, disease, treatment, and payment for my treatment for the purpose of obtaining patient support services including investigation of my health insurance coverage, communicating with me about my experience, providing support services, and operating and administering the program. I understand that once my information has been released to Molecular Biologicals and its affiliates, federal privacy laws may no longer protect the information from further disclosure, but that Molecular Biologicals and affiliates intend to use this information for purposes of this authorization or otherwise allowed by law. I understand I may refuse to sign this authorization and it will not impact my ability to obtain medical care, insurance coverage, or access to health benefits including access to treatment. However, by not signing, Molecular Biologicals can not provide these support services. This authorization will expire after two years from the date I signed. I may decide to withdraw this authorization at any time by sending a written notice that includes my name, address, and phone number to RxTalents, LLC ATTN: Patient Services, 4900 Carlisle Pike, Mechanicsburg, PA 17050

By signing below, I certify that I have read and understand the Authorization to Release Personal Health Information and agree to its terms. I understand that I may request a copy of this Authorization.

Patient or Legal Representative Signature Required _____ Printed Name _____

Date / / Relationship to Patient _____ Email _____

FINANCIAL ASSISTANCE PROGRAM PATIENT AUTHORIZATION

I acknowledge that my personal and insurance information stated on this form is correct. I acknowledge that I am responsible for paying any out-of-pocket expenses up to the program maximum. I authorize Molecular Biologicals and its affiliates to contact me by mail, phone, cell phone, voice mail, email, or text message regarding the financial assistance program and insurance information.

By signing below, I certify that I have read and understand the Financial Assistance Program Authorization and agree to its terms.

Patient or Legal Representative Signature Required _____ Printed Name _____

Date / / Relationship to Patient _____ Email _____

Additional Information Needed:

Prescription from your doctor for Keragel / Keramatrix / Keragel T