HIPAA Compliant
(Health Insurance Portability and Accountability Act of 1996)

Hearts Enteral DME Patient Assistance Enrollment Form

PATIENT INFORMATION

FIRST NAME | LAST NAME

DATE OF BIRTH | AGE | SS # (Optional) | GENDER □ MALE □ FEMALE

STREET ADDRESS | APT# | CITY | STATE | ZIP

EMAIL ADDRESS | EMPLOYMENT STATUS

□ CHILD □ EMPLOYED F/T □ EMPLOYED P/T □ UNEMPLOYED
□ DISABLED □ SELF-EMPLOYED □ STUDENT □ OTHER

PHONE | WORK NUMBER | OTHER PHONE

GENETIC DISORDER

DISORDER	CURRENT MEDICAL FOOD	AMOUNT PER DAY	CURRENT DME/PHARM

CLINIC INFORMATION

DIETITIAN/PHYSICIAN	CLINIC	PHONE #	FAX #

RESPONSIBLE PARTY / PARENT / CAREGIVER (GUARANTOR) INFORMATION

RELATIONSHIPTO PATIENT: □ SELF □ CHILD □ SPOUSE □ PARENT □OTHER _____

FIRST NAME	LAST NAME		PHONE NUMBER #

PRIMARY INSURANCE INFORMATION

INSURANCE NAME	PHONE NUMBER	MEMBER ID #	GROUP #

MEMBER NAME	MEMBERS DATE OF BIRTH	RELATIONSHIP TO MEMBER

DO YOU HAVE A SECONDARY HEALTH PLAN?

☐ YES or ☐ NO

If yes please add your secondary health plan_____

INSTRUCTIONS

Hearts Enteral is partnered with Compassion Works Medical, LLC of Wayne New Jersey.

- Hearts Enteral DME is an out-of-network supplier and is not contracted with any health insurance plans. All of our billing would be based on a gap exception / in-network waiver approved by your health plan in order to be reimbursed at your in-network benefit level.

- We **do not** accept straight State Medicare and Medicaid health plans. We will consider Managed Medicare and Medicaid health plans.

- All health plans vary and may not honor gap exception / in-network waivers. Should this be the case, we will notify you in advance to help find an alternative solution.

- Once the applicant supplies all required supporting information in the application process, Hearts Enteral makes its decision within 10 to 12 business days.

- Once approved, please submit your orders directly to Hearts Enteral at rfranco@heartsenteral.com and in the subject line enter "New Order – Product Name (and your initials)" or call us at 973-832-4736 and ask for Raenette Franco or Michael Magzanian.

- Patients have the right to remove themselves from the program at any time. There are no annual re-enrollments. Hearts Enteral has the rights to remove any patients at any time with false informaiton.

Signature Required ***

Authorization for Release of Health Information: *I HEREBY AUTHORIZE RELEASE OF HEALTHCARE INFORMATION. This information contained herein may be shared to Hearts enteral, LLC and its affiliates for quality purposes to ensure that the necessary resources are available to service you for medical food supplier and reimbursment support. Such information is furnished in compliance with* ***HIPAA*** *to allow for the best service.* ***I also understand and agree to Hearts Enteral' s Notice of Privacy Practices.*** *Nonetheless, if you do not wish for this information to be shared with Hearts Enteral call (973) 832-4736 and our HIPAA Privacy Officer will assist you with this request and ensure that the information is not shared.*

Signature of applicant: _____ **Date:** _____

Representative of applicant: _____ **Date:** _____

Representative Title: _____

PLEASE ATTACH THE FOLLOWING DOCUMENTS:

- ✓ **HEALTHCARE PROVIDER FORM/ DIAGNOSIS VERIFICATION**
- ✓ **HIPAA AUTHORIZATION FORM**
- ✓ **RECENT PERSCRIPTION(S)**
- ✓ **LETTER OF MEDICAL NECESSITY**
- ✓ **COPY OF INSURANCE CARD (FRONT & BACK)**

IMPORTANT: PLEASE FAX OR EMAIL COMPLETED DOCUMENTS TO: HEARTS ENT – DME PROGRAM ADMINISTRATOR, ATTN: RAENETTE FRANCO, FAX (973) 387-1223 OR EMAIL rfranco@heartsenteral.com .