FRESENIUS KABI
caring for life

KabiCare
Patient Support Program by Fresenius Kabi

KabiCare® Nutrition Resources Patient Enrollment Form

Email: **info@kabicarenutrition.com** • Phone: **1-844-540-5224 (KABI)** • Fax all pages to: **1-866-416-7542**

PATIENT SECTION

Requested Service

☐ Benefit Investigation ☐ Prior Authorization Assistance ☐ Appeal/Denial Assistance ☐ All

Patient Information

Full Name: _____ DOB: ____/____/_____ (MM/DD/YYYY) Sex: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Preferred Phone #: ____-____-_____ ☐ Home ☐ Cell E-mail: _____

Insurance Information: (Please send a copy of front and back of insurance card with this form.)

Primary Medical Insurance Carrier: _____ **Secondary Medical Insurance Carrier:** _____

Policyholder Name: _____ Relationship to patient: _____ Policyholder Name: _____ Relationship to patient: _____

Policyholder ID Number: _____ Group Number: _____ Policyholder ID Number: _____ Group Number: _____

Insurance Phone: ____-____-_____ Insurance Phone: ____-____-_____

Required Patient Authorization and Additional Consents

I have read and agree to the Patient Authorization to Share Personal Health Information and Nutrition Resources Enrollment (Section 1).

Patient Signature (not care partner): _____ Date of Signature: ____/____/_____ (MM/DD/YYYY)

PRESCRIBER SECTION

Prescribing Physician Information

Full Name: _____ Office Contact Name: _____

Business/Practice Name: _____ Office Phone: ___-___-_____ Contact Phone: ___-___-_____

Address: _____ City: _____ State: _____ Zip: _____

Fax: _____ E-mail: _____

Tax ID #: _____ NPI #: _____ PTAN #: _____

Site of Care: ☐ Freestanding Infusion Center ☐ Hospital Outpatient ☐ Physician Office

Product and Diagnosis Information

Patient Diagnosis

ICD-10-CM Diagnosis Code(s): _____

Please select the appropriate product and indicate the HCPCS: ☐ Omegaven ☐ SMOFlipid ☐ Kabiven ☐ PeriKabiven

HCPCS Codes – Please select the correct HCPCS codes for this request:

☐ B4187, 10 Grams Lipids (Omegaven) Total Grams: ____ ☐ B4189, 10 – 51 Grams of Protein (Kabiven or PeriKabiven)

☐ B4185, 10 Grams Lipids (SMOFlipid, Kabiven, or PeriKabiven) Total Grams: ____ ☐ B4193, 52 – 73 Grams of Protein (Kabiven)

☐ B4197, 74 – 100 Grams of Protein (Kabiven)

Required Signature and Physician Attestation

You must authorize these instructions by signing (Section 2). We cannot process this form without your signature.

Prescriber Signature: _____ Date of Signature: ____/____/_____ (MM/DD/YYYY)

CANNOT BE PROCESSED UNLESS ALL FIELDS ARE COMPLETED

3003-KCPN-03-07/22

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ADDITIONAL TERMS AND CONDITIONS FOR ENROLLMENT

Section 1:

Required Patient Authorization and Additional Consents

PATIENT AUTHORIZATION AND RELEASE TO COLLECT, USE, AND DISCLOSE HEALTH INFORMATION

I understand that I must authorize the use and disclosure of certain personal health information (PHI) before I can receive assistance through the KabiCare Nutrition Resources Program (the Program). I hereby authorize my healthcare providers, pharmacies, and health plan(s) to disclose my PHI related to my medical condition and treatment, and all information provided on this patient enrollment form, to the Program and its agents. I further authorize the Program to use and disclose my PHI for the purposes of establishing my eligibility for benefits from my health insurance plan or other programs, providing educational and reimbursement support, and communicating with my healthcare providers and health plan(s). I understand that signing this authorization is voluntary and that if I were to refuse to sign, that would not affect my eligibility for health plan benefits or ability to obtain treatment by my healthcare providers. I also understand, however, that if I refuse to sign, I will not have access to the services offered by the Program. I also understand that if I sign this authorization, I can cancel it at any time by notifying the Program in writing at info@kabicarenutrition.com. Upon receiving my notice of cancellation, the Program would stop using this authorization to access, use,or disclose my PHI, and would notify my healthcare provider(s) and health plan(s) of the cancellation, but the cancellation would not invalidate reliance on the authorization prior to its cancellation. I understand that once disclosures of my PHI pursuant to this authorization have occurred, that PHI may no longer be protected by certain federal or state privacy laws and therefore could potentially be re-disclosed to others. This authorization will expire 5 years after the date it is signed or at such earlier time as may be required by applicable state law. I have read this authorization or have had it explained to me. I understand that I will receive a copy of this authorization after I sign it.

Section 2:

Required Signature and Physician Attestation

PRESCRIBER AUTHORIZATION

I verify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed this Fresenius Kabi product based on my professional, independent judgment of medical necessity and it will be used as directed. I certify that I have received the appropriate permission from the patient and have met any other applicable requirements imposed under the Health Insurance Portability and Accountability Act of 1996 and/or state law needed to release the above information to the KabiCare Nutrition Resources Program (the Program) and its agents for the purposes of verifying the patient's insurance coverage, on my patient's behalf, and providing information on prior authorization and/or appeals for denials of claims. I authorize the Program to provide the described reimbursement assistance for the above-named patient regarding this Fresenius Kabi product as may be required by the patient's health plan. I further authorize the Program to submit, at my request, information provided by me on this form and documentation completed by me to applicable health plans.

Disclaimer: Results of any verification of benefits or coverage that are reported by any patient's health insurance plan are not a guarantee of coverage or reimbursement, and the KabiCare Nutrition Resources Program disclaims liability for payment of any benefits, claims or costs.

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