Reset Form

good days

Please review enrollment information below. Complete form by filling in missing information. Make any corrections by writing changes next to the information provided.

Date:	*If approved you may be responsible for a nominal copay per dispensed medication.*
SSN:	

PATIENT INFORMATION

Patient's Name:	Birth Date:
Alternate Contact:	Relationship:
Mailing Address:	Home phone:
	Cell Phone:
	Work Phone: Ext:
E-mail Address:	

INCOME INFORMATION

Annual Household Income:	Number of people in household:

PHYSICIAN INFORMATION

Physician Name:	Physician Phone:
Office Address: (*if known*)	Physician NPI:

DIAGNOSIS INFORMATION

Diagnosis:	
Medication:	
Pharmacy:	Pharmacy Address or Phone: (*if known*)

MAJOR MEDICAL INSURANCE INFORMATION

Insurance Name:		
ID#:	Group #:	Phone:

DRUG CARD INFORMATION

Insurance Name:	ID#	
BIN:	PCN:	Phone:

Is this a Medicare, Federal or State funded insurance plan? Yes No *(circle applicable answer)*

******THIS PAGE MUST BE RETURNED******

6900 Dallas Parkway, Suite 200, Plano, TX 75024
877-968-7233 ● Fax 214-570-3621 ● www.mygooddays.org

*Metastatic Cancer Diagnoses

For patients in a metastatic cancer fund: If your physician has prescribed a drug to treat your metastatic cancer that is not on Good Days' formulary, please contact us. We may be able to cover the prescribed drug if we receive additional documentation showing that the drug otherwise meets our criteria. For our metastatic cancer funds, Good Days will cover all drugs approved by the Food and Drug Administration (the "FDA") that treat the type of cancer that is the basis of the disease fund into which you have been accepted. For example, if you have metastatic breast cancer, Good Days will cover all drugs that are approved by the FDA to treat breast cancer, not just those drugs that the FDA has expressly approved for the metastatic stage of breast cancer.

Declaration and Consent

You attest and certify to Good Days and its agents that the information provided in your application is complete and accurate. You understand that, and consent to, your reported financial information being verified by an audit as deemed necessary by Good Days. Good Days, and its authorized third party agents, such as credit monitoring companies, may use your demographic information, including but not limited to your social security number, date of birth, name, and address in order to estimate your income in conjunction with the eligibility process. You understand that Good Days, and its authorized third party agents, reserve the right to ask for additional documents and information at any time. As a soft credit inquiry, this does not impact your credit score.

You further understand that any false or incomplete information provided by you to Good Days could unduly harm your application process, Good Days, its reputation, and its tax exempt status. You also understand that any financial assistance provided to you by Good Days may be recouped, if Good Days becomes aware of any inaccurate information or fraudulent activity relating to your application or the assistance provided to you. You understand that you are free at any time to switch providers, practitioners, suppliers, or treatments within the Good Days formulary for your diagnosis without affecting your continued eligibility for assistance.

You understand that you are not guaranteed or promised assistance. Any assistance Good Days may provide is limited to the terms and conditions established by Good Days. Good Days reserves the right at any time, and for any reason without notice, to modify the eligibility criteria or modify or discontinue any assistance.

Terms of the Consent Pertaining to the Disclosure of your Personal Information

In order for you to receive assistance through Good Days, you authorize your physicians, pharmacies and insurance companies to disclose to Good Days and its applicable contractors, employees, agents and other representatives your personal information. In addition you authorize Good Days to use and disclose your personal information to Good Days' agents, third parties acting on its behalf, credit monitoring companies, or any of your healthcare providers.

Your personal information may include, but not be limited to, your name, address, phone number, email address, date of birth, social security number, insurance status and numbers, amount of financial assistance allocated and dispensed, diagnosis information, and treatment information.

CONTINUED ON NEXT PAGE…

You consent to the disclosure of your personal information (i) to enable Good Days to determine whether you are eligible and qualify for financial assistance for any medication(s); (ii) to enable Good Days to provide financial assistance to you for your medication(s); (iii) to refer you to, or to determine your eligibility for, other programs, foundations or alternate sources of funding or coverage for your healthcare costs, products and services; (iv) to facilitate the audit or review of Good Days' operations; and (v) to enable Good Days to manage its patient assistance programs.

You understand that your personal information that is disclosed may be re-disclosed by the recipient and no longer protected by federal or state privacy regulations and laws. You consent to Good Days electronically disclosing your personal information to third parties as permitted or required by law.

You may revoke this consent at any time by mailing a signed letter of revocation to Good Days' Privacy Officer at 6900 Dallas Parkway, Suite 200, Plano, TX 75024 or faxing the written revocation to Good Days' Privacy Officer at the following fax number: (214) 570-3636. Revoking this consent will not have any effect on actions that Good Days took in reliance on the consent before it received notice of your revocation. If you revoke this consent, you will not be able to receive future assistance through Good Days.

This consent expires six years from the date that you last receive assistance from Good Days, if not revoked sooner.

Limitation of Liability

You agree that Good Days, our sponsors, and our donors shall not be liable for any damages of any kind, without limitation, arising out of or in connection with you receiving financial assistance, co-pay relief, or other value-added benefits or services provided as a part of this program.

Patient Attestation

You agree to be fully compliant in taking the drug for which financial assistance is being provided in accordance with your doctor's directions

By signing below you agree that you have read, understand and agree to adhere to the above statements

Signature of Individual or Individual's representative _____ Date _____

Print name of Individual's representative: (If applicable) _____ Relationship (If applicable) _____

******THIS PAGE MUST BE RETURNED******