Reset Form

C·A·R·E
Crescendo Access & Reimbursement Essentials

Crescendo Bioscience, Inc. Financial Assistance Program Application

PATIENT INFORMATION

FIRST NAME | M.I. | LAST NAME

DATE OF BIRTH (MONTH/DAY/YEAR)

CELL/PRIMARY PHONE | ALTERNATE PHONE

EMAIL ADDRESS

PATIENT CERTIFICATION

- If I do not have insurance, I certify I am not eligible for Medicare, Medicaid, or any other state or government health insurance and will not seek reimbursement from any insurance carrier or government agency for Vectra® DA fees waived by Crescendo Bioscience.
- If I have insurance, I certify that I will not seek reimbursement from any insurance carrier or government agency for Vectra DA fees that are my financial responsibility.
- I certify that the information contained in this application is correct to the best of my knowledge. I understand this information will not be used for any other purpose unless I give written consent, or to the extend necessary to document my eligibility under the CARE program.
- I certify I will notify the Crescendo Access and Reimbursement Essentials (CARE) Program within 30 days if there is any change in my eligibility status with regard to income and health care coverage. I will provide documentation, including but not limited to personal financial records, which are necessary to verify the information contained in this application.

PATIENT SIGNATURE | DATE

The Crescendo Access and Reimbursement Essentials (CARE) Program reserves the right to modify or discontinue this program with respect to any patient or in its entirety, at anytime.

Please email this form to: care@crescendobio.com or FAX back to: 801-883-8965
Crescendo Bioscience, CARE Program
Crescendo Billing | PO Box 581108 | Salt Lake City, UT 84158-1108

CRESCENDO BIOSCIENCE® A MYRIAD COMPANY

Español (Spanish)
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繁體中文 (Chinese)
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注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-877-743-8639。