The Gift of Sight
by Roanoke Valley Center for Sight
Financial Needs Assessment Questionnaire

ROANOKE VALLEY CENTER FOR SIGHT

Vistar Eye Center
Vision & Surgery Specialists

*Do not leave any lines blank

Applicant Name: _____ Social Security: _____

Address: _____ Date of Birth: _____

City, State, Zip: _____ Phone #: _____

Employer: _____

Hourly Wage: _____ Hours per week: _____

Spouse Name: _____ Social Security: _____

Employer: _____ Date of Birth: _____

Hourly Wage: _____ Hours per week: _____

Patients Name: _____

Persons living in your household:

Name: _____ Date of Birth: _____ Relationship: _____

Name: _____ Date of Birth: _____ Relationship: _____

Name: _____ Date of Birth: _____ Relationship: _____

Monthly Bills $:

Utilities: _____ Water: _____

Cars: _____ Phone: _____

Other: _____

Total Monthy Bills: _____

Monthly Income (household):

Pension: _____ Alimony: _____

Disability: _____ Public Assist.: _____

Soc. Sec. #: _____ Child Support: _____

Unemployment: _____ Other: _____

Total Monthly Income: _____

Are you buying or do you own any real estate (house, lot, land, building, or any part interest in real estate? Yes ☐ No ☐

Mortgage Payment $: _____ Total Value of all Real Estate $: _____

Total owed on Mortgage $: _____

Address of Property: _____

Any Health Insurance? Yes ☐ No ☐ Health Insurance Name: _____

Eye Doctor Name: _____

FOR OFFICE USE ONLY:

Referral Form: _____ Reason for Referral: _____ Date of Referrral: _____

Organizations Available:

Medicaid: Yes___ No___ Project Access: Yes___ No___ Visual Handicap: Yes___ No___

Account Number: _____ Account Manager: _____

The Gift of Sight 2023
by Roanoke Valley Center for Sight

Financial Needs Assessment Questionnaire

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Vistar Eye Center
Vision & Surgery Specialists

I understand that this form will be used to evaluate my ability to pay my medical bill. I agree to cooperate with Roanoke Valley Center for Sight in pursuing reimbursement from any available insurance or medical payment programs and verifying the information on this form. I understand that all or part of my indebtedness to Roanoke Valley Center for Sight may be reduced if I qualify under the current Compassionate Care Program guidelines.

I hereby certify that the information contained on this questionnaire is correct and accurate, and I hereby authorize any and all parties to release any information necessary to confirm the information on this questionnaire including the amount of my assests and income. I further authorize and agree that Roanoke Valley Center for Sight may obtain credit reports with respect to me.

Printed Name _____ **Signature** _____ **Date** _____

What is Roanoke Valley Center for Sight's (RVCS) Compassionate Care Program?

RVCS is committed to providing quality health care to all regardless of one's ability to pay. PVCS will consider all income, equity in realty property, federal poverty guidelines and other factors to determine the amount, in sole judgment of RVCS; a patient is reasonably able to pay. All patients who are able will be expected to pay for his/her own health care services to avoid shifting the burden for their care to other patients and the general public.

To apply, complete this confidential questionnaire and return to:

Gift of Sight Day
Attn: Staci Runyon
P.O. Box 1789
Roanoke, VA 24008-1789

If you have any questions or need help completing this form, please call: (540) 855-3554

***When returnng this form, please send a copy of your latest tax return, W2 form, a financial statement, and copy of monthly bills**

Approval Signature: _____ **Date:** _____

Surgical Patient Assistance Program (S-PAP)

Application

AlconCares™

ACI Contact Information
Telephone: 800.222.8103
Fax: 866.594.1579
Email to: surgical.pap@alcon.com

Surgery Scheduler Contact Information

Surgery Facility Name and Acct. Number: _____

Surgery Facility Contact Name: _____

Surgery Facility Contact email: _____

Patient Information

Patient Name: _____

Does the patient have Medicare? ☐ Yes ☐ No Medicare Plan Type: _____

Patient Authorization: I certify that I have provided my prescribing physician with all of the necessary consents authorizing him/her to release my health information to ACI. Unless revoked, this authorization will remain in effect for the duration of my participation in the program.

Declaration Regarding Privacy: I understand and agree that ACI and parties working on its behalf may use and disclose my information to determine my eligibility for this program; administer and improve ACI programs, products, and services; communicate with me about my experience with this program; send me educational materials and other helpful information and updates relating to ACI programs; and/or as ACI believes to be necessary or appropriate under applicable law, to submit required reports and government filings, to comply with legal processes, to respond to requests from government authorities, and to protect our rights, privacy, safety, or property. I further understand that, once my information is disclosed, ACI cannot control how the recipients will further use or disclose my information.

Declaration Regarding Incurred Drug Expenses: I understand and agree that the value of any free medications provided to me pursuant to this program does not count as true out-of-pocket spending ("TrOOP") under Part D of the Medicare program or any other prescription drug plan. I further agree that I will seek no reimbursement for any medications obtained under this program.

Patient Acknowledgment: I acknowledge that my participation in the program is subject to ACI's approval and ACI expressly reserves the right to refuse my participation. Please indicate your agreement with these terms by signing below.

Patient Signature: _____ Date: _____

Power of Attorney is permissible, but appropriate documentation must be provided to ACI when the patient is physically unable to sign the application. Witness of signature by healthcare provider office personnel is permissible when the patient has trouble signing his/her name and the healthcare provider office personnel signs that he/she witnessed the patient signing his/her name.

Surgical Patient Assistance Program (S-PAP)

Application

AlconCares™

Surgery Facility Name: _____

Surgery Facility Contact Email: _____ Surgery Facility Contact Name: _____

Surgery Facility Street Address: _____

City: _____ State: _____ ZIP Code: _____ Phone: _____

Healthcare Provider State License #: _____ State: _____

Healthcare Provider Name: _____
First *Last*

Healthcare Provider Business Hours: _____ Office Contact Name: _____

Tax ID #: _____ Medicare Provider #: _____

The products listed will be credited to the healthcare provider's account. **ACI recognizes the fact that the prescribing healthcare provider has the sole responsibility in determining the product best suited for his/her patient.**

Patient Name: _____ DOB: _____

Surgery Type (cataract, glaucoma, vitreoretinal, etc.): _____

Alcon Products Used (except IOLs)

Product Number	Lot Number	Description	Quantity

Note: Only list surgical products sold or distributed by Alcon. This program does not apply to products sold or distributed by Novartis.

Alcon IOLs Used

Lens Style	Serial Number	Diopter	Left or Right Eye

If you require additional lines, please copy this form and complete the product section with the additional products and attach it to the application.

I certify that the patient qualifies for this program.

I further certify that the information provided in this form is correct and I understand that the products provided to the qualifying patient will be credited to my account. Neither I nor the facility will submit any claim for reimbursement to any public or private third party payer (e.g., Medicaid, Medicare, private insurance, etc.) for the products used on a qualifying patient under this program.

I further certify that I have obtained all necessary consents authorizing me to release protected health information to ACI. Neither I nor the facility will charge any patient receiving free product under this program or any third party for services performed by me or the facility.

I further understand that products provided under this program may not be sold or traded and may not be returned for credit. My signature below confirms that I agree to these terms as further articulated in the Guidelines attached and that there is a valid medical need for this patient's surgery.

Healthcare Provider's Signature: _____ Date: _____

If applicable, collaborating Physician's Name: _____

State License #: _____

Please indicate account number to receive credit: _____

OMIDRIAssure®

SUPPORT AT EVERY STEP

Instructions for Enrolling in the Equal Access Patient Assistance Program

For the Patient

1. Complete all relevant fields on the Patient Enrollment Form (reverse side of this page)
2. Sign the Patient Enrollment Form (reverse side of this page)

For the Physician

3. Complete all relevant fields on the Patient Enrollment Form and sign the Physician Certification (reverse side of this page)
4. Upload via the OMIDRIAssure portal (omidriassure.com) or fax completed form with legible copies of front and back of each applicable insurance card to +1-855-616-7741
5. Form must be completed and approved 10 business days prior to date of surgery

If your patient meets the eligibility criteria for the Equal Access Patient Assistance Program, OMIDRIA® (phenylephrine and ketorolac intraocular solution) 1% / 0.3% will be provided at no cost for use during your patient's surgery.

FOR PERSONALIZED HELP, CALL THE LIVE ASSISTANCE REIMBURSEMENT HOTLINE AT 1-877-OMIDRIA (1-877-664-3742) Option #5

OMIDRIA®
(phenylephrine and ketorolac intraocular solution)
1% / 0.3%

Patient Enrollment Form

OMIDRIAssure®
SUPPORT AT EVERY STEP

The top section of the form (above the line) should be completed and signed by the patient or patient's legal representative. The bottom section of the form (below the line) should be completed and signed by the physician prior to surgery. A printout of the patient's electronic medical record may be substituted for relevant sections of this form.

PATIENT INFORMATION (Note: only US residents are eligible)

First Name | Last Name

Date of Birth | Adress (not PO box)

City | State | Zip Code

FINANCIAL INFORMATION (used to evaluate request for patient assistance)

Total Number of People in Household (including Patient)
Total Yearly Household Income (including salary/wages;
Social Security income; disability income; any other income)*
*Supporting documentation may be requested.

PATIENT CERTIFICATION

By signing below, I certify that the information I have provided on this application, along with any supporting documentation, is complete and accurate. I authorize my physician to release any necessary information to OMIDRIAssure's® purveyor to evaluate my eligibility for the Equal Access Patient Assistance Program. I understand that OMIDRIAssure representatives may review and verify my eligibility and may contact me or my physician for additional information. If requested, I agree to provide proof of my stated income or any other eligibility requirements as requested. I acknowledge that Rayner Surgical Inc. may change or terminate OMIDRIAssure and/or the Equal Access Patient Assistance Program at any time without prior notice.

Signature of Patient or Patient's Legal Representative

Printed Name | Date

Relationship to Patient (if Patient's Legal Representative)

This section of the form should be completed by the physician.

PATIENT INSURANCE INFORMATION

Does the patient have medical and/or prescription benefits through any private commercial or government health insurance program? (If yes, please provide a legible copy of each applicable insurance card.) Yes No

PHYSICIAN INFORMATION

Physician Name | NPI No./DEA No.

Patient Diagnosis ICD-10 Codes

Procedure Code CPT Code | Date of Surgery

Facility/Practice Name

Address (not PO box) | City

State | Zip Code | Phone | Fax

Site Contact Name

PHYSICIAN CERTIFICATION

My signature below certifies that the patient named above is my patient and that the information provided is, to the best of my knowledge, complete and accurate. I have obtained the patient's authorization to disclose his or her personal and health information to the OMIDRIAssure program to use and to disclose as necessary in connection with the possible provision of patient and/or reimbursement support services. If the patient is uninsured or functionally underinsured and is eligible for the Equal Access Patient Assistance Program, I agree that OMIDRIA®, provided at no cost, will be used only for the patient named on this form and will not be offered for sale, trade, or barter and that no claim for reimbursement of OMIDRIA will be submitted to Medicare, Medicaid, or any other third-party payer. I consent to Rayner Surgical Inc. representatives and agents contacting me to confirm receipt of OMIDRIA or to provide additional information about OMIDRIA and the OMIDRIAssure program. I agree that Rayner Surgical Inc. may change or terminate any of the OMIDRIAssure program services at any time without notice.

Signature of Physician | Date

Dispense: OMIDRIA 4-mL vial	Qty 1 Qty 2	Sig: Dilute 4 mL of OMIDRIA in 500 mL of ophthalmic irrigation solution. Must be administered by, or under the supervision of, a physician.	Refills: 0

For Indications and Important Safety Information, please read the Full Prescribing Information at www.omidriahcp.com/prescribinginformation.

Rayner

OMIDRIA®
(phenylephrine and ketorolac intraocular solution) 1% / 0.3%