Patient Assistance Program Application

Send completed and signed forms to: Fax: 888-975-0603 or Email: help@usephil.com. To submit your application online, visit our **Patient Assistance Program** page on the EndeavorRx website.

Section 1: Patient Personal Information

Patient Name: _____

Gender: ◯ Male ◯ Female ◯ Other ◯ Prefer Not to Say **DOB:** ____ /____ /____

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

Parent / Legal Guardian Name: _____ **Relationship to Patient:** _____

Parent / Legal Guardian Phone: _____ **Parent / Legal Guardian Email:** _____

Parent / Legal Guardian Social Security Number: _____

Section 2: Parent / Legal Guardian Financial Information

Number of people in your household: **Adults =** _____ **Children =** _____

Total combined income for you, your spouse, and your dependents: $ _____ Annually

Section 3: Insurance Information

What type of insurance coverage covers the patient named on the prescription? (Check all that apply)

◯ **Medicare Part A** ◯ **Medicare Part B** ◯ **Medicare Part D** ◯ **Medicare Advantage**

◯ **Medicare Aid** ◯ **State Pharmacy** ◯ **Other** _____ ◯

For each policy you have that provides coverage for the patient, please attach a copy of both sides of your insurance card and fill in the following:

Primary Insurance

Insurance Plan: _____

Phone Number: _____

Name of Policy Holder: _____

Policy Holder DOB: _____

Policy ID: _____

Group Number: _____

Plan Type: _____

Secondary Insurance

Insurance Plan: _____

Phone Number: _____

Name of Policy Holder: _____

Policy Holder DOB: _____

Policy ID: _____

Group Number: _____

Plan Type: _____

Patient Authorization

I certify that the information I have provided in this form is accurate and complete. I authorize Phil Pharmacy and Akili Interactive Labs, Inc. to use my information to determine eligibility for financial assistance or as otherwise permitted by law. Submission of this form does not constitute approval or guarantee eligibility to receive discounted services. The guidelines for providing hardship assistance may change or the program may be discontinued without notice. By submitting this form, you consent to Phil pharmacy processing your and your child's data and personal information in accordance with Phil's Privacy Policy and Phil's HIPAA Notice for the purposes of patient assistance qualification. By signing, I certify that I have read and agree to the patient authorization above.

_____ _____

Parent/Legal Guardian Signature Date

EndeavorRx By AKILI