Enrollment Application for Seeta Eye Foundation

23 Davis Avenue, Poughkeepsie, NY 12603 Phone: 845-454-1025
SeetaEyeFoundation@aol.com

Dear Patient,

Thank you in your interest in the Seeta Eye Foundation.
To be eligible for the Seeta Eye Foundation patients must:

•Be a U.S. Resident • Meet the income requirements

What to do:

- Patient completes and signs Patient Section (page 2)
- Attach copies of all required financial documentation
- HCP completes and signs Procedure Section (page 3)
- Email or mail form with documentation.

The following procedures are available:

Femtosecond Laser for cataract surgery (LenSx)
ORA
Toric Intraocular Lens
ReStor Multifocal Intraocular Lens
Tecnis Multifocal Intraocular Lens
iStent
CyPass

Patient Name:_____	**FINANCIAL INFORMATION**: Attach a copy of your

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Address:_____
City:_____State:_____
Zip:_____Cell phone #_____
Secondary Phone #_____
US Resident □ Y □ N Gender: □ M □ F Veteran □ Y □ N
Disabled □ Y □ N (Status deemed by social security)

Social Security # (Required)_____OR
Green Card ID # (If applicable)_____
Date of Birth: _____/_____/_____

Procedure #1_____
Procedure #2 _____

Caregiver/ Family Member:_____
Address:_____
City:_____State:_____
Zip:_____Phone#:_____

household's most recent year's tax returns (1040, 1040EZ, 1099, unemployment check, 3 months paychecks or bank statements, etc.)

Do Not send original documents with your application.

Total # of people in the home (including self, please add all those who are living with you)
□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 or more
# of Children:_____# of Adults_____

List all sources of Gross Monthly Income:
Salary/Wages (All Sources): $_____
Pension/Retirement: +$_____
Social Security: +$_____
Disability: +$_____
Unemployment Benefits: +$_____
Alimony/Child Support: +$_____
Total Gross Monthly Household Income: =$_____

PATIENT INSURANCE INFORMATION: Please Include a copy of the front and back of your Prescription Card and Insurance Card (REQUIRED)

	Coverage	Identification No.	Phone Number	Effective Date
Medicare Part B	□ Y □ N			
Medicare Part D	□ Y □ N			
Medicaid	□ Y □ N			
State Children Health Insurance	□ Y □ N			
Veterans Assistance	□ Y □ N			
Other –	□ Y □ N			

Please Read, Sign and Date below, Missing Signature or date may cause a delay in processing.

I give permission for my doctor(s) and their staff to disclose my personal information, including information about my insurance, prescription, medical condition and health ("Health Information") to the Seeta Eye Foundation, so that the Foundation can decide if I am eligible for the Seeta Eye Program; ask me for financial, insurance and/or medical information and share my information as required or permitted by law. I give permission to the Foundation to use information to this Application and any other information I give to the Foundation for these same reasons. I also give the Foundation permission to share my Health Information and other information with people and companies that work with the Foundation; government agencies, including the Centers for Medicare and Medicaid Services; insurance companies, including Medicare Part D plans; my doctor(s) and other people or institutions who are involved in my healthcare, such as pharmacies and hospitals; other organizations that might help me pay for my procedure. I promise that any information, including financial and insurance information that I provided to the Foundation are complete and true and unless I have said something different in this application. ** If my income or health coverage changes, I will call the Seeta Eye Foundation at 845-454-1025. I know that the Foundation may change or end at any time. I know that if I do not sign this form, I wil not be able to participate, but this will not affect my ability to get medical care, seek payment for this care or affect my enrollment or eligibility of insurance. I know that I can cancel this permission at any time by calling the Seeta Eye Foundation at 845-454-1025. If I do, then I will not be able to stay in the Seeta Eye Foundation. I understand I have the right to receive a copy of this form.

Patient or Legal Guardian Signature(Required)_____Date(Required)_____/_____/_____

HEALTH CARE PROFESSIONAL (HCP) INFORMATION: To be completed by the HCP.

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HCP Full Name_____

Address:_____

City:_____State:_____Zip:_____

Phone:_____Fax:_____

DEA/State License #: _____NPI #_____

Patient Coordinator/ Nurse Advocate:_____

Address:_____

City:_____State:_____Zip:_____

Phone:_____Fax:_____

PATIENT PROCEDURE:

Procedure #1 _____

Procedure #2_____

Please list patient's allergies No Known □ Or_____

Required Signature:_____Date_____/_____/_____

Read, Sign and Date HCP Authorization, Missing Signature or Date May Cause A Delay in Processing

My signature below certifies that the person listed above is my patient for whom I have recommended the procedure identified above. ** I certify that any procedures received from the Seeta Eye Foundation (as defined above) in connection with this application will be used only for the patient named on this form. These procedures will not be offered for sale, trade, or barter. Additionally, no claim for reimbursement will be submitted concerning these procedures to Medicare, Medicaid, or any third party, nor will any procedures returned for credit. I acknowledge that I have assisted the patient in enrolling in the Seeta Eye Foundation exclusively for purposes of patient care and not in consideration for, expectation of, or actual reveipt of remuneration of any osrt. I also agree that Seeta Eye Foundation has the right to contact the patient directly to confirm receipt of medications, and I understand that Seeta Eye Foundation may revise, change, or terminate this program at any time. Finally, to the best of my knowledge, that patient listed above meets Seeta Eye Foundation eligibility criteria for the Seeta Eye Foundation.

Prescriber Signature (REQUIRED)_____DATE_____/_____/_____

Patient did you:	HCP did you:

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☐ Complete, sign and date Patient Section? ☐ Attach copies of all required income and prescrip documentation? ☐ Discuss Seeta Eye Foundation enrollment with HCP? If you have checked all the boxes above, you are ready to submit the form!	☐ Fill out the HCP information Section? ☐ Sign and Date the Procedure Section? ☐ Sign and Date the HCP Authorization? If you have checked all the boxes above, you are ready to submit the form!

Follow these steps to complete your application process:

1. Mail pages 2 and 3 of the Application with income and Insurance Documentation to:
   Seeta Eye Foundation
   23 Davis Avenue
   Poughkeepsie, NY 12603

   OR

2. Email pages 2 and 3 of the Application with income and Insurance Docuementation to:
   SeetaEyeFoundation@aol.com

We will review and process your application once we receive the completed application with supporting financial documentation.

If you have any questions, please call a Seeta Eye Foundation Representative at 845-454-1025 Monday through Friday 8:00 am to 5:00 pm EST.