PAXMAN HUB ENROLLMENT FORM

PLEASE NOTE: HCP MUST HAVE A CONTRACT WITH PAXMAN TO PRESCRIBE FOR THIS SERVICE.

HCP site:
paxmanscalpcooling.com
Patient site:
coldcap.com

PAXMAN HUB
PO BOX 29264
PHOENIX
AZ 85038-9264
PHONE: 8445PAXMAN
FAX: 888-358-0410

SECTION 1: ALL
STEP 1. PATIENT INFORMATION
STEP 2. PRESCRIBER INFORMATION
STEP 3. PATIENT PRIVACY INFORMATION
STEP 4. TREATMENT AND PRESCRIPTION INFORMATION
STEP 5. PRESCRIBER/PHYSICIAN AUTHORISATION

SECTION 2: SELF PAY
FINANCIAL ASSISTANCE

SECTION 3: NEW BUSINESS MODEL (BUY AND BILL) CONTRACTS ONLY
STEP 1. PATIENT FINANCIAL INFORMATION
STEP 2. PATIENT INSURANCE INFORMATION
STEP 3. PAP SUPPORT SERVICES PATIENT CERTIFICATION

SECTION 4: CAP OR COVER SWAP

PLEASE COMPLETE THE INFORMATION BELOW AND FAX TO **888-358-0410**

- SELF PAY (ORIGINAL BUSINESS MODEL; COMPLETE SECTION 1 & 2)
- PROVIDER BILLS INSURANCE – BUY AND BILL MODEL (REQUIRES NEW CONTRACT WITH PAXMAN – CONTACT **HCP@PAXMANUSA.COM** OR **888-572-9626**; COMPLETE SECTIONS 1 & 3)

SECTION 1: ALL PATIENTS

STEP 1 - PATIENT INFORMATION - PLEASE USE LEGAL NAME OF PATIENT (*Required Fields)

First Name*: | MI: | Last Name*:

DOB*: (/ /) | Sex: M F

Address*:

City*: | State*: | Zip*:

Patient Home Phone*:
Patient Mobile Phone*:
Preferred Number to Call: Home Mobile

Is the Patient a US Resident?: Yes No

Patient Email Address: | Tick box to opt-out of receiving educational and marketing material:

Authorized Representative (First and Last Name):

Relationship to Patient: Patient Authorized Representative

Authorized Representative Phone: | Email:

STEP 2 - PRESCRIBER AND FACILITY INFORMATION (*Required Fields)

Prescriber Name* (First and Last): | Prescriber Tax ID #*:

Prescriber Address*:

City*: | State*:

Zip*: | Fax*:

Prescriber Contact Phone*: | Prescriber State License Number*:

Email Address*: | Preferred Method of Contact*: Phone Email

Office Contact Name: | Office Contact Phone:

Supervising Physician*: | Supervising Physician Phone*:

Facility Name*:

PAXMAN HUB ENROLLMENT FORM

Patient Full Name*	Patient DOB*	Prescriber/Physician Name*	NPI#*

STEP 3 - PATIENT PRIVACY AUTHORIZATION (*Required Fields)

I authorize my health care providers, pharmacies, and health insurer(s) to disclose my personal information, including information about my insurance, prescriptions, medical condition and health ("Personal Information") to Paxman, its affiliates, business partners, service providers, third-party contractors, and agents (together, the Paxman Hub) so that the Paxman Hub can provide me with the Patient Support Services available for the Paxman Scalp Cooling Cap prescribed by my HCP on this Enrollment Form. Paxman Support Services include: (i) help to verify or coordinate insurance coverage or otherwise obtain payment for my treatment with this product including to locate alternative funding sources , (ii) coordinate my receipt of, and payment for this product, (iii) facilitate my access to this product, (iv) provide me with information about this product and management programs and educational materials, (v) manage the Patient Support Services, (vi) provide me with adherence reminders and support, and (vii) conduct quality assurance, surveys, and other internal business activities in connection with the Patient Support Services. I give permission to the Paxman Hub to disclose my Personal Information to my health care providers, pharmacies, health insurer(s), and other third-party contractors or service providers for the purposes described above.

I understand that my pharmacy, health insurer(s), and health care providers may receive remuneration (payment) from Paxman in exchange for disclosing my Personal Information to Paxman and/or for providing me with therapy support services. I understand that once my Personal Information is disclosed it may no longer be protected by federal privacy law. I understand that I can refuse to sign this Authorization and that this will not affect my treatment, insurance coverage, or eligibility for benefits from any third party payor to which I would otherwise be entitled; however, if I do not sign this Authorization, Paxman will not be able to provide Patient Support services to me. I also may revoke this authorization at any time in the future by writing to PO Box 29264, Phoenix, AZ 85038-9264. If I revoke this authorization, I may no longer be eligible to participate in the Patient Support Services. If I revoke this authorization, the Paxman Hub will stop using or sharing my information (except as necessary to end my participation in the Services) but my revocation will not affect uses and disclosures of my Personal Information previously disclosed in reliance upon this authorization. I understand that this authorization will remain valid for five years after the date of my signature, or such shorter period as required by State law, unless I revoke it earlier. I also understand that the Patient Support Services may change or end at any time without prior notification. I understand that I have the right to receive a copy of this form.

Patient/Legal Guardian/Authorized Representative*:	Date:

I appoint the person named below to act as a representative for me and/or my minor child. I authorize the representative to receive, discuss, and disclose my personal information. This authorization does not give the representative authority over treatment or direct-care decisions.

First Name*:	Last Name*:
Relationship to Patient:	
Primary Phone:	Secondary Phone:

STEP 4 - TREATMENT AND PRESCRIPTION INFORMATION AND PRESCRIBER/PHYSICIAN AUTHORIZATION (*Required Fields)

ICD-10 Diagnosis Code*:	Additional Diagnosis Code:
Therapy Start Date*:	CPT Codes: 0662T Used once only / 0663T Per treatment Additional Diagnosis Code: L65.9

Directions: **Use as directed**	Quantity: **One**

Cap/Cover Size ☐ New Patient ☐ Recurrence ☐ S/S ☐ M/S (Medium cap/inner, Small cover/outer) ☐ M/M ☐ L/L

Prescribed Treatment Days*: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Other No. of Treatment Days:

Refill: Do not include initial treatment days received

Date of Refill:	No of treatments:	Date of Refill:	No of treatments:
Date of Refill:	No of treatments:	Date of Refill:	No of treatments:
Date of Refill:	No of treatments:	Date of Refill:	No of treatments:

☐ **Refund (check completed treatment days)**

Completed Treatment Days: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

STEP 5 - PRESCRIBER/PHYSICIAN AUTHORIZATION – MANDATORY FOR PROCESSING (*Required Fields)

I certify that (i) the information contained on this form is accurate to the best of my knowledge and (ii). I am the prescribing healthcare provider of Paxman Scalp Cooling Cap to the previously identified patient and that I provided the patient with the description of the Paxman program. For purposes of transmitting this prescription, I authorize Paxman US, Inc. and its affiliates, business partners, and agents, to forward as my agent for these limited purposes, this prescription electronically, by facsimile, or by mail to a dispensing pharmacy.

Dispense as Written: ☐ *If this form does not meet your state's requirements for a valid prescription, please attach a valid prescription (or eprescribe).*

Prescriber Signature*:	*Can be signed by NP or PA - but must put name of supervising MD in step 2 above.*	Date:

PAXMAN HUB ENROLLMENT FORM

Patient Full Name*	Patient DOB*	Prescriber/Physician Name*	NPI#*

SECTION 2: SELF PAY PATIENTS

FINANCIAL ASSISTANCE REQUESTED FOR SELF PAY PATIENTS

Financial Assistance Requested: Yes ☐ No ☐	Financial Assistance Approved (If Known): Yes ☐ No ☐
Foundation Name:	

SECTION 3: ONLY HEALTH SYSTEMS WITH NEW BUSINESS MODEL (BUY AND BILL) CONTRACT WITH PAXMAN

IF UNSURE CONTACT HCP@PAXMANUSA.COM OR TOLL FREE #888-572-9626

STEP 1

Facility Tax ID:	Facility NPI #:

STEP 2 - PATIENT ASSISTANCE (Required only for Patient Assistance Program under the Reimbursement Model)

Employment Status: ☐ Employed ☐ Unemployed	Number of People in Household:
Current Annual Household Income ($):	

Please see full Prescribing Information at coldcap.com.

Fax completed form to 1-888-358-0410. For complete program details, **visit** www.coldcap.com or **call** 1-844-572-9626.

STEP 3 - PATIENT INSURANCE INFORMATION (Attach a copy of the patient's insurance/Medicare/Medicaid card, front and back, if available.)

Does the Patient have Health Insurance?:	Primary Medical Insurance Provider:
ID #:	Group #:
Beneficiary/Cardholder Name:	Insurance Phone:
Secondary Medical Insurance Provider:	
ID #:	Group #:
Beneficiary/Cardholder Name:	Insurance Phone:

PAXMAN HUB ENROLLMENT FORM

STEP 3 - PAP SUPPORT SERVICES PATIENT CERTIFICATION (Signature Required for PAP) (*Required Fields)

Paxman Patient Assistance Program ("PAP") provides the Scalp Cooling Cap at no cost to patients who are uninsured or underinsured and meet all eligibility requirements of the PAP program.

Paxman reserves the right to review assistance based on patient need and to change the enrollment form, program guidelines or terminate the program at any time without notification. I acknowledge that no free product received via the PAP program may be submitted for reimbursement to any payer, including Medicare and Medicaid; nor may be sold, traded, or distributed for sale. I understand that Paxman Patient Assistance Program ("PAP") assistance will terminate if the PAP becomes aware of any fraud or noncompliance with this certification, or if this product is no longer prescribed for me. I will notify the Paxman Hub immediately of any changes in my insurance, income or prescription status. I also understand that I am responsible for compliance with any tax reporting obligations associated with the assistance I may receive, and I should consult a tax professional if I have questions.

I understand that:
- completing this application does not ensure that I will qualify for patient assistance.
- this program is not meant to induce a physician to use or prescribe the Paxman Scalp Cooling Cap, or to induce me to utilize the Paxman Scalp Cooling Cap.
- if I qualify for free product, it will be for the remainder of the current calendar year, and should I require assistance in future years, I must reapply for Paxman PAP assistance.
- the Paxman PAP reserves the right to modify the application form, modify or discontinue this program or terminate assistance at any time and without notice.
- the Paxman PAP reserves the right to request documentation to verify the information provided in this application for purposes of determining my eligibility for assistance and to conduct periodic audits of my enrollment, including the physician who will be supervising my treatment, to verify the information provided herein.
- I may opt out of the Program at any time by writing to the Paxman Hub at PO BOX 29264, PHOENIX AZ 85038-9264 or calling 1-844-5PAXMAN (844-572-9626).
- assistance received through the Paxman Patient Assistance Program is not insurance.

If I am eligible or enrolled in a Medicare plan, I will:
- receive the requested product from the Paxman Patient Assistance Program for the remainder of the enrollment calendar year for which my application was approved, and I will
- not seek the requested product from my Medicare plan for the remainder of the enrollment calendar year;
- not seek true out-of-pocket (TrOOP) credit for any product received from the Program because I understand that the product received from the Program will not count toward my TrOOP; and agree to notify my Medicare plan that I will receive my Paxman product for free until the end of the year through the Program.

By signing this form:
- I certify that I am at least eighteen (18) years of age and that I have read and agree to the above Patient Certification and the terms and conditions of the Paxman Patient Assistance Program.
- I also certify that all information that I have provided in this application is complete and accurate.
- I authorize Paxman and its Vendors to use and share information about me with my healthcare providers and insurance company for the purpose of coordinating my enrollment and my participation in the PAP program.
- I also authorize Paxman and its Vendors to contact me by mail, or telephone in connection with the PAP program and to inform me of available assistance programs, treatment and therapies, and insurance related information.

Patient First Name*: | Patient Last Name*:

Name of Authorized Representative (if applicable):

Relationship to Patient:

Patient/Legal Guardian/Authorized Representative Signature*: | Date:

SECTION 4: CAP OR COVER SWAP ONLY

TO BE COMPLETED IN THE EVENT A CAP/COVER SIZE SWAP IS REQUIRED (*Required Fields)

CHANGE REQUEST - CAP/COVER SIZE SWAP - DO NOT USE FOR INITIAL ORDER

☐ S/S ☐ M/S ☐ M/M ☐ L/L

Medium cap/inner, Small cover/outer

In the event that the patient determines a different cap size is required after taking delivery, physician is required to check the box for new size required, re-sign below and re-fax to Paxman Hub 888-358-0410.

Please note - Prescriber Signature required here only for Cap/Cover Size Swap.

Prescriber Signature*: | Date: