



Patient Attestation Form

Name _____ Date of birth ____/____/____ Sex ☐ Male ☐ Female
First Last (mm / dd / yyyy)

Address _____ City _____ State _____ Zip code _____

Do you have any changes in health insurance information? ☐ No ☐ Yes
 Do you have any changes in household income?(other than cost of living adjustment) ☐ No ☐ Yes
 Has your home address changed? ☐ No ☐ Yes
 Has your prescribing Crexont provider changed? ☐ No ☐ Yes

If you answered **Yes**, to any of the questions above, please complete the relevant section below to update your information.



Complete the section(s) below **only if** your health insurance, household income, or US residency has changed. If you answered **No**, to all questions, proceed to the bottom of the form to provide your attestation.

Patient Insurance Information - Do you have insurance through any of these providers. Check all that apply

☐ Medicare: ☐ Part A ☐ Part B ☐ Part C/Medicare Advantage ☐ Part D ☐ Part D LIS/Extra Help
☐ Medicaid ☐ VA or Military ☐ Private Insurance ☐ None ☐ Other: _____

	Primary Insurance	Secondary Insurance	Prescription Insurance
Insurer name			
Plan name			
Plan phone number			
Name of plan Subscriber			
Subscriber relationship to patient			
Membership ID/Policy #			
Group			
Medicare Membership ID (11 digit alpha/numeric) #	_____ - _____ - _____		☐ Not applicable

Your Household Income

How many people live in your household and are dependent on your household income (include yourself)? _____
 What is your total household income? \$ _____

US Residency

Mailing address: _____ City: _____ State: _____ ZIP: _____

Caregiver (optional)

Caregiver First Name _____ Last Name _____
 Telephone number (____) _____ Relationship _____

I have spoken to my caregiver, and they agree to receive non-marketing calls from the Amneal Patient Assistance Program at the number provided, and I authorize the Amneal Patient Assistance Program to speak to my caregiver about my health condition and regarding the program.

Please complete and sign the section below

I acknowledge that submission of this patient attestation form does not guarantee continued eligibility. I understand that to remain eligible for free drug program, I must continue to meet the eligibility criteria. By signing below, I attest that the responses that I have provided are true and accurate.

Signature of patient _____

Printed Name of Patient _____

Today's Date MM/DD/YYYY _____