Indigent Patient Product and Cellular Data Plan Donation Request Form

This Request Form must be fully completed and sent to Boston Scientific Corporation to the applicable address specified below in order to be eligible to receive a charitable donation of product for use in an indigent patient's care. Upon receipt of the completed Request Form, Boston Scientific will determine if the request meets its indigent care product donation criteria.

Use the tab key to quickly move from field to field. • Hover the mouse over any field for completion hints.

Return to Boston Scientific via e-mail by clicking here: Email

Or return completed **typed** form to Boston Scientific via fax to 1.877.382.2954 by printing the completed form by clicking here: Print Form

Click Here To Save Form
(this can be done before or after completing the form)
Save

Boston Scientific CRM considers all information provided on this form to be confidential. We maintain physical, electronic, and procedural safeguards that maintain the confidentiality of this information. All information provided on this form will be handled in a manner described in our company's Code of Business Conduct and confidentiality policies. Within Boston Scientific CRM, we restrict access to confidential information to only those employees or agents who need access in order to provide products and services to our customers; to those who need access to perform quality, regulatory, operational, or compliance functions; and to those whose access to confidential information is required by law or regulation.

Privacy of patient information during transmittal to Boston Scientific is the responsibility of the sender.

ALL FIELDS ARE REQUIRED and must be completed before the form can be processed.

I. Application Information

LATITUDE Following Clinic: | Street Address: | City: | ST: | Zip: | Clinic Federal Tax ID:

Contact Person Name: | Contact Person Telephone: | Contact Person Email:

II. Patient & Device Information (required for FDA purposes)

Patient Name: | DOB (MM-DD-YYYY): | PG Model #: | PG Serial #: | Communicator Model #: | Communicator Serial #:

III. Service Requested and Shipment Destination for Cable or Adapter (Patient or patient advocate)

Attention To: | Recipient Address (cannot ship to PO Box): | City: | ST: | Zip: | Receipt Telephone:

What type of service is needed:
- Internet - Ethernet Cable
- Cell (Adapter)

USB adapter model provided? Yes No | USB Model #: | USB Serial #: | Ethernet Adapter Provided? Yes No

IV. Request Information

Describe the history of past indigent care donations from Boston Scientific:

IV. CERTIFICATION. The undersigned hereby certifies that (Please initial these statements in the box):

- *I am a representative of, and am authorized to sign this Request Form on behalf of, the institutional health care provider identified above.*
- *The patient with the above described Boston Scientific product requires LATITUDE cellular access, is uninsured or does not have an annual income greater than 150% of the federal poverty guidelines, and qualifies for free services from our institution pursuant to our institution's indigent care policy.*
  Please see the federal poverty guidelines at http://aspe.hhs.gov/poverty/13poverty.cfm#guidelines
- *The patient does not have land line telephone service. ·No charges or fees have been nor will be billed by our institution or members of our medical staff or any other physician to the patient or a third party payor, nor will be collected from the patient or a third party payor for the LATITUDE Cellular Data Plan and Cellular Adapter to the patient. Third party payors include a federal, state, or other governmental health care program or an insurer or similar entity.*
- *Our institution has not and will not include the value of the Boston Scientific product donated for use in an indigent patient (i) as "bad debt," or (ii) toward any legal obligation our institution may have to provide free care.*
- *Our institution shall retain a copy of this completed Request Form and all other communications regarding this donation, together with all invoices or other documentation regarding the free product, and shall permit agents of the U.S. Department of Health and Human Services, U.S. Internal Revenue Service, or any state agency access to such records upon request.*
- *In the event of a product recall, Boston Scientific or its designee will notify the Institution. The institution will carry out the terms of the recall. ·I understand that Boston Scientific will only provide patients requiring LATITUDE cellular access with a three (3) year fee waiver.*

At the end of such time, should patient require continued LATITUDE cellular access, our institution will have to reapply for LATITUDE cellular access for that patient and I understand that Boston Scientific is not obligated to continue to waive fees associated with LATITUDE cellular access for the patient.

V. LATITUDE User Information

First Name: | Last Name: | LATITUDE User ID:

If Boston Scientific, in its sole discretion, determines that this request meets Boston Scientific's Compassionate Use requirements, Boston Scientific will send the product requested above. Scan and e-mail or fax this completed form to the Cardiac Rhythm Management within Boston Scientific:

Reset Form

Thank you for providing us with this information.
If you have any questions or comments, contact
Customer Service at 1-855-221-5686 or Email
lowincomeprogram@bsci.com

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16022-001
2013-10 ENUS

071361, Indigent Patient Product and Cellular Data Plan Donation Request Form, Revision AG