Intravenous Immunoglobulin (IVIG) Demonstration Beneficiary Application

This application is for Medicare beneficiaries that are currently or planning on using intravenous immunoglobulin therapy in the home. The demonstration will provide a per-visit payment for nursing and supplies needed for the administration of IVIG. For more guidance on how to complete this application, please see "Enrollment Application Guide". This document is available on http://med.noridianmedicare.com/web/ivig or by calling 844-625-6284

TYPE OR PRINT INFORMATION								
Section I: Beneficiary Information								
	Name of Beneficiary from Health Insurance Card (Last) (First)	(N	11)	2	Date of Birth (mm/dd/yyyy)			
1				3	Email Address			
4	Medicare Health Insurance Claim (HIC) Identification #			5	Telephone Number (Include Area Code)			
6	Mailing Address				Gender () Male 7 () Female			
8	Do you currently live in the same household with a spouse, extended-family or friend? () Yes () No							
	SECTION II: Medication Information							
9	Approximately what year did you start receiving immunoglobulin medication?							
10	I receive (or intend to start receiving) the immunoglobulin () Intravenously (IV) i.e. in your vein				ously i.e. under your skin			
	Note: Do not answer this question if you receive your medication subcutaneously. I usually receive my IV immunoglobulin at: (Check all that apply)		med Prov	<i>licat</i> videi	o not answer this question if you receive your ion subcutaneously. Name and Address where you receive your inoglobulin medication:			
11	[] Home [] Doctor's office [] Outpatient Hospital Department/Infusion Center	11a						
12	Note: Do not answer this question if you receive your model of the currently receive (or am scheduled to receive) my intraversity () Twice a month () Every 3-4 weeks ()	venous	s imm	uno	-			

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12a	Note: Do not answer this question if you receive your medication subcutaneously.		Note: Do not answer this question if you receive your medication subcutaneously.						
	I sometimes miss receiving my IV immunoglobulin		If yes, indicate the reason (Check all that apply):						
		12b	[] Cannot afford it	[] Not feeling well					
	() Yes () No		[] Transportation	[] Other:					
	Note: Do not answer this question if you receive your r	nedic	eation intravenously.						
13	I currently receive my subcutaneous immunoglobulin medication:								
	() Weekly () Twice Weekly	()	Other:						
4.4	My participation in this Medicare demonstration will (Ch	eck (all that apply):						
	[] Reduce the time spent traveling to and from, and at the provider's office/hospital for intravenous administration								
	[] Reduce my absence from daily activities								
	[] Reduce my out of pocket payments for receiving the medication intravenously								
	[] Reduce exposure to infection								
14	[] Reduce the risk of impaired driving attributed to reaction to infusion								
	[] Improve my overall quality of life								
	[] Other:								
	SECTION III: Payment Information	n o	of IVIG Administration	on Charges					
	SECTION III: Payment Information This section asks questions to understand how you currently pay for the IVIG administration charges (nursing and supplies other than the medication itself).	n o	Note: Skip this se	on Charges ction if you currently ation subcutaneously.					
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SECTION IV: Beneficiary Signature

I understand that application to participate in this demonstration does not guarantee that I will be selected to participate and that, if selected, participation in this demonstration is voluntary and I can withdraw at any time.

	Beneficiary Signature		Date				
17							
SECTION V: Physician Signature							
18	Physician Name (<i>Printed</i>)						
19	Physician Phone number	20	Individual NPI				
I attest that I am treating this patient, that the patient has primary immune deficiency disease, and is a candidate for home IVIG.							
21	Physician Signature		Date				

If you wish to participate, you must complete, sign and submit an application, as space and funding for this demonstration are limited. Both you and your physician must sign the application.

You may mail your application to this address:

Noridian Healthcare Solutions IVIG Demo PO Box 6788 Fargo ND 58108-6788

For overnight delivery, mail your application to:

Noridian Healthcare Solutions IVIG Demo 900 42nd Street South Fargo ND 58103

You can fax your completed application to: 701-277-2428

If there's space available after the initial enrollment period, we will accept and review applications as they come in until we fill all slots.

Submitting an application for this demonstration doesn't guarantee that we will select you to participate.

For helpful IVIG Demonstration information and guidance on how to complete this application, visit http://med.noridianmedicare.com/web/ivig and see the "Enrollment Application Guide". Call the IVIG Demonstration at 844-625-6284 for help with the form, or with questions about the IVIG Demonstration.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1246 (expires 04/30/2018). The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Atm: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. **CMS Disclosure:** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact Jody Blatt (Jody.Blatt@cms.hhs.gov).

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