Form Approved
OMB No. 0938-1246

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

1	Name of Beneficiary from Health Insurance Card *(Last)* *(First)* *(MI)*	2	Date of Birth (*mm/dd/yyyy*)
		3	Email Address
4	Medicare Health Insurance Claim Identification Number	5	Telephone Number (*Include Area Code*)
6	Mailing Address	7	Gender ☐ Male ☐ 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 medication: ☐ Intravenously (IV) i.e. in your vein ☐ Subcutaneously i.e. under your skin		
11	**Note:** *Do not answer this question if you receive your medication subcutaneously.* I usually receive my IV immunoglobulin at: (*Check all that apply*) ☐ Home ☐ Doctor's office ☐ Outpatient Hospital Department/Infusion Center	11a	**Note:** *Do not answer this question if you receive your medication subcutaneously.* Provider Name and Address where you receive your IV immunoglobulin medication:
12	**Note:** *Do not answer this question if you receive your medication subcutaneously.* I currently receive (or am scheduled to receive) my intravenous immunoglobulin medication: ☐ Twice a month ☐ Every 3-4 weeks ☐ More than twice a month ☐ Other: _____		

12a	**Note:** *Do not answer this question if you receive your medication subcutaneously.* I sometimes miss receiving my IV immunoglobulin medication: ☐ Yes ☐ No	12b	**Note:** *Do not answer this question if you receive your medication subcutaneously.* If yes, indicate the reason (*Check all that apply*): ☐ Cannot afford it ☐ Not feeling well ☐ Transportation ☐ Other: _____
13	**Note:** *Do not answer this question if you receive your medication intravenously.* I currently receive my subcutaneous immunoglobulin medication: ☐ Weekly ☐ Twice Weekly ☐ Other: _____		
14	My participation in this Medicare demonstration will (*Check 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 ☐ Reduce the risk of impaired driving attributed to reaction to infusion ☐ Improve my overall quality of life ☐ Other: _____		

SECTION III: Payment Information of IVIG Administration Charges

*This section asks questions to understand how you currently pay for the IVIG administration charges (*nursing and supplies *other than the medication itself).*

Note: Skip this section if you currently receive this medication subcutaneously.

15	Who currently pays for the cost of nursing and supplies associated with this drug (not the cost of the drug itself)? If you are currently not taking this medication but plan to, who do you expect will pay for these expenses if you do not participate in the demonstration (*Check one*): ☐ I pay for it all ☐ I pay for most of it , but some costs have been covered through insurance or a drug assistance plan ☐ Most of the costs are paid by insurance or a drug assistance plan ☐ I receive the drug at a physician/hospital department/outpatient infusion center; and do not pay any cost ☐ I don't know
16	Check the other health insurance that covers the nursing and supplies associated with this drug. If you are currently not taking this medication but plan to, check the other health insurance that will cover the nursing and supplies associated with this drug if you do not participate in the demonstration (*Check all that apply*): ☐ Medicaid ☐ Veteran's benefit ☐ Retiree/spouse's employer health plan ☐ Privately-purchased policy (not Medi-gap) ☐ State or county program other than Medicaid ☐ Pharmacy company program ☐ I don't know ☐ TRICARE ☐ None ☐ Other: _____

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.

17	Beneficiary Signature	Date

SECTION V: Physician Signature

18	Physician Name (*Printed*)		
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.**