Enrollment Form

Enrollee Information (please print)

Name

Date of Birth (mm/dd/yyyy)

Address

City State ZIP

Telephone Number

E-mail Address

Physician Information (please print)

Physician Name

Institution/Practice

Address

City State ZIP

Telephone Number

Health Insurance Information (please print)

Insurance provided by:

- ☐ Private Insurance
- ☐ State-sponsored
- ☐ Medicare
- ☐ Medicaid
- ☐ Uninsured

Primary Insurance Company Name

Telephone Number

Subscriber Name

Policy ID Number

Patient's Authorization and Certification

I verify that the information provided in this enrollment form is complete and accurate. I authorize PAREXEL (an independent program administrator) to obtain medical and insurance coverage information, as necessary to complete the enrollment process. I have read the conditions of the program and understand eligibility for this program is based on certain requirements. I understand that Baxter reserves the right to deny or approve any program enrollment form and reserves the right to modify or discontinue the program at any time.

I further understand that the Alpha-1 Security portion of the Alpha-1 AATmosphere program has additional eligibility requirements. If product is required under Alpha-1 Security, a supplemental enrollment form will be required to verify eligibility.

Please note: All information and documentation obtained in relation to enrollment in the Alpha-1 AATmosphere program will be held in strict confidence by PAREXEL and will not be shared with Baxter or any other party.

Enrollee Signature (mandatory for enrollment) Date

Mail to:

AATmosphere
PO Box 231990
Centreville, VA 20120-1990

Fax to:

1-800-752-0595

We respect your privacy. The information you provide will only be used for purposes for which you have provided it. Please note that when you contact Baxter directly, you will be providing personally identifiable information to Baxter. When you submit personally identifiable information, you consent to its disclosure and use for these purposes. We suggest that you do not send clinical or medical information via e-mail. We may share your information with our partners who facilitate the delivery of this information. If you ever decide that you do not wish to receive information from us regarding our programs and services, contact us at: Baxter Customer Service, One Baxter Parkway, Deerfield, IL 60015 or at 1-800-423-2090. If you have any questions, comments, concerns, or complaints about our information practices, call 1-800-422-9837 (U.S.) or 847-948-4770 (outside of the U.S.), fax your inquiry to 847-948-3642, or send us mail at Parexel, 5870 Trinity Parkway Suite 500, Centreville, VA 20120-9913.

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