OTSUKA PATIENT ASSISTANCE FOUNDATION, INC.
PO Box 501878, San Diego, CA 92150-1878
PHONE: 1-855-727-6274 **FAX**: 1-844-727-6274

Otsuka PATIENT ASSISTANCE FOUNDATION

INCOME/INSURANCE/RESIDENCY ATTESTATION LETTER

PATIENT INFORMATION:

First Name: _____ Last Name: _____

DOB (mm/dd/yyyy): _____ Phone: _____ Email: _____

PRESCRIBER INFORMATION:

First Name: _____ Last Name: _____

State License #: _____ Tax ID #: _____

NPI #: _____ DEA #: _____

Direct Contact's First and Last Name: _____

Site Name: _____

Site Address: _____ City: _____ State: ____ ZIP: _____

Contact's Direct Phone: _____ Ext: ____ Contact's Fax: _____

Contact's Email: _____

MESSAGE:

Dear Otsuka Patient Assistance Foundation, Inc (OPAF):

To the best of my knowledge, the above-named patient cannot provide proof of income, and/or documentation of insurance, and/or US address information. As such, I am attesting to the patient's current income, and/or insurance status and U.S address information.

The patient's current household income is $_____ Number of People in Household: _____

Check all that apply:

☐ The patient is currently uninsured.

☐ The patient is currently insured but does not have coverage for this medication. If attaching copies of both medical and pharmacy cards do not fill out the insurance section below.

MEDICAL CARD: Payer Name: _____ Plan Name: _____ Phone: _____

Policyholder Name: _____ Member ID: _____ Group#: _____

PHARMACY CARD: Payer Name: _____ Plan Name: _____ Phone: _____

RxBIN: _____ RX PCN: _____

☐ The patient is currently residing in the United States at the following address:

Street: _____ City:_____ State: _____ Zip: _____

I understand that if any changes occur to the patient's income, insurance status, and/or address, the Otsuka Patient Assistance Foundation, Inc. (OPAF) will be notified immediately. I also understand that with said changes, the patient's eligibility in the program may change.

Sincerely,

Prescriber's Name: _____

Sign here _____ **Date**: (mm/dd/yyyy) _____