** This form is not a prescription.*

Fertility Preservation

Fertility Preservation Form

Program Requirements: -Cash-only patients; -Female patients only who are about to undergo cancer treatment; -Must be a U.S. Citizen or permanent resident.

Complete all fields in the following form and keep a copy for your records. Incomplete applications will not be processed.

Note: You should discuss the risks, side effects and other aspects of all treatment options with your patient before recommending the best course of treatment. If at any time you have advised or do advise your patient to seek treatment for cancer immediately, it is the position of First Steps that the patient should not delay treatments in order to receive these services.

PATIENT INFORMATION

Last Name:

First Name: **Middle Name:**

Address:

City: **State:** **Zip Code:**

Primary Phone: **Secondary Phone:**

Email: **Social Security Number:** ###-##-####

Race/Ethnicity: African American ☐ **Cancer Type:**

Gender: Male **Date of Birth:** MM/DD/YYYY

INSURANCE INFORMATION

Company Name: **Policy Number:**

Group Number: **Telephone Number:**

Subscriber Name:

Subscriber Relationship to Patient: Self ☐ **uninsured**

AUTHORIZED REPRESENTATIVE

☐ **Give First Steps permission to speak with another party regarding my First Steps Fertility Preservation application.**

Name: **Relation:** Self

Primary Phone: **Email:**

APPLICANT CERTIFICATION AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Certify that the information provided in this application is complete and accurate. I authorize the release of the information contained in this application. I understand it is for the sole use of First Steps, its representatives and/ or agents in order to assess my eligibility for participation in First Steps Fertility Preservation.

☐ **Patient has accepted and provided authorization.**

PLEASE SUBMIT YOUR ENROLLMENT FORM AND INCOME VERIFICATION TO ONE OF THE FOLLOWING:

Certify that the information provided in this application is complete and accurate. I authorize the release of the information contained in this application. I understand it is for the sole use of First Steps, its representatives and/ or agents in order to assess my eligibility for participation in First Steps Fertility Preservation.

MAILING ADDRESS:
2181 E. AURORA RD STE. 201
TWINSBURG, OHIO 44087

EMAIL: firststeps@envisionrx.com
FAX: 855-672-9262

*You will receive an email within 24 hours from the time it is entered into the system. Please check your junk and spam folder for your notification as it tends to filter into there at times. ** Please note that anything submitted on Friday's will not receive a response until the following business day. The First Steps program is closed weekends and all major holidays.***

Your signature below certifies that I have completed all of the above sections completely, accurately, and to the best of my knowledge, and that I have read, understand, and agree to the terms of this enrollment form and the attached Authorization to use and disclose health and other personal information.

PATIENT SIGNATURE: **DATE** _____ /_____ /_____

Offer not valid for prescriptions that may be covered under a Federal or State healthcare program, including Medicare, Medicaid, TRICARE, the Department of Veterans Affairs, the Department of Defense, or any other similar state healthcare program, including any state medical pharmaceutical assistance program.

** This form is not a prescription.*