Coherus COMPLETE™
The clear choice for patient support

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Patient Financial Services Self-Enrollment Form

Call 1-844-4-UDENYCA (1-844-483-3692)
Monday to Friday • 8 AM to 8 PM ET
FAX 1-877-226-6370
www.CoherusCOMPLETE.com

Please complete and submit this form to enroll in patient financial services. A Patient Access Specialist will contact you to discuss program eligibility.

All fields in orange are required to be completed before form submission.

1 PATIENT INFORMATION

Patient's Name: Sex: ☐ Male ☐ Female DOB: (MM/DD/YYYY)

Patient's Address: City: State: ZIP:

Patient's Preferred Phone #: ☐ Home ☐ Cell Email:

2 INSURANCE INFORMATION (PLEASE ATTACH A COPY OF BOTH SIDES OF THE PATIENT'S INSURANCE CARD(S). IF NOT AVAILABLE, PLEASE COMPLETE THE INFORMATION BELOW.)

PRIMARY MEDICAL INSURANCE

Check the appropriate box: ☐ MEDICARE ☐ MEDICAID ☐ COMMERCIAL/PRIVATE ☐ OTHER ☐ UNINSURED

Insurance Name:

Medicare Beneficiary ID# (if applicable):

Phone #: Policy ID #: Group #:

Policyholder's Name: Policyholder's Date of Birth:

Policyholder's Relationship to Patient:

SECONDARY MEDICAL INSURANCE (If Applicable)

Check the appropriate box: ☐ MEDICARE ☐ MEDICAID ☐ COMMERCIAL/PRIVATE ☐ OTHER ☐ UNINSURED

Insurance Name:

Medicare Beneficiary ID# (if applicable):

Phone #: Policy ID #: Group #:

Policyholder's Name: Policyholder's Date of Birth:

Policyholder's Relationship to Patient:

3 PRESCRIBER INFORMATION

Prescriber's Name:

Practice/Facility Name: Phone #:

Mailing Address: City: State: ZIP:

4 PATIENT AUTHORIZATION

I, _____ (Print Name) authorize my healthcare provider to share my protected health information, including health insurance with Coherus BioSciences, Inc., its affiliates, its program administrator, and their respective agents, service providers, and field reimbursement professionals for the purpose of providing patient support programs, including benefit investigation, co-pay assistance, and patient assistance as part of the treatment with Coherus products (collectively referred to as, "Coherus COMPLETE™"). I authorize Coherus COMPLETE™ to use and/or disclose my protected health information, including health insurance to other Coherus-affiliated service providers for purposes of providing services and programs described above. My refusal or future revocation will not affect the commencement or continuation of my treatment by my provider; but, if I do not sign or I revoke this authorization, I will no longer be eligible to participate in the Coherus COMPLETE™ Support Programs. If I revoke this authorization, my revocation will not affect protected health information previously disclosed in reliance upon this authorization. I understand that this authorization will remain valid for 5 years after the date of my signature and that I may revoke (withdraw) this authorization at any time in the future by contacting my provider.

Signature (Required): _____ Date _____

Coherus BIOSCIENCES