

**FACILITY ENROLLMENT INFORMATION**

**Instructions:**

- A facility must enroll in The Safety Net Foundation in order to participate in the product replacement program.
- The Safety Net Foundation cannot provide assistance for inpatient hospital use.
- This form should be completed by a facility contact to begin the facility enrollment process.
- This form only needs to be submitted once per facility.

FACILITY APPLICATION FORM				
<b>Facility Type</b>	<input type="checkbox"/> Dialysis Center <input type="checkbox"/> Hospital <input type="checkbox"/> Free Standing <input type="checkbox"/> Pharmacy	<input type="checkbox"/> Hospital <input type="checkbox"/> Specialty <input type="checkbox"/> Community	<input type="checkbox"/> Non-Dialysis Center or Pharmacy <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> Infusion Facility	Other (please specify):
<b>Facility ID #</b>	DEA #:	NPI #:	Facility HIN#	AHA #:
<b>Facility Mailing Information</b>	Facility Name:			
	Contact Person First Name:	Contact Person Last Name:	Contact Title	
	Phone #: ( ) -	Fax #: ( ) -	Contact Email:	
	Street Address:			
<div style="display: flex; justify-content: space-between; border-top: 1px solid black; margin-top: 5px;"> <span>_____ Street</span> <span>_____ City</span> <span>_____ State</span> <span>_____ Zip</span> </div>				
Is the Facility "Ship To" address the same as the mailing address above?  <input type="checkbox"/> Yes <input type="checkbox"/> No		<b><i>If Yes,</i></b> ➤ skip to Third Party Administration information section (page 2) <b><i>If No,</i></b> ➤ complete the rest of the Facility Shipping Information section below		



Facility Name: \_\_\_\_\_

**FACILITY CERTIFICATION FORM**

By submitting this application, I agree to the following:

- I will provide Amgen products for patients in a medically appropriate manner based on a valid physician's order or prescription.
- I understand that The Safety Net Foundation reserves the right to change or terminate this program at any time, or to refuse to distribute Amgen products under this program to any patient or facility.
- I understand that product is provided on a replacement basis. Participating providers are required to stock the product and apply for replacement product through The Safety Net Foundation.
- I understand that an insurance verification may be required to determine a patient's eligibility for The Safety Net Foundation.
- I understand that the product received through The Safety Net Foundation is for medically needy patients living in the United States and its territories.
- I certify that I will not charge or cause any other party to charge any third party or patient for Amgen products for which replacement is sought under The Safety Net Foundation. I further certify that all product received in connection with The Safety Net Foundation will replace such product; be furnished free of charge for treatment of needy patients who meet The Safety Net Foundation criteria; and, that no part of any charges for Amgen products replaced under The Safety Net Foundation will be claimed as bad debt.
- I understand that The Safety Net Foundation is available for outpatient use only. I certify that no replacement will be requested for product administered in the hospital inpatient setting.
- I represent that the information contained in all patient applications under my facility, including the patient application form will be complete and accurate to the best of my knowledge. This representation does not require my independent investigation of the information. If I become aware of any changes in the patient's circumstances that affect The Safety Net Foundation eligibility, I agree to notify The Safety Net Foundation immediately.
- I agree to release or make available to an authorized The Safety Net Foundation representative the medical and financial records for The Safety Net Foundation patients who have provided consent for such disclosure for the sole purpose of verifying patients' eligibility for The Safety Net Foundation. I agree that I will not provide patient information without obtaining appropriate consent from each patient prior to releasing or making available to The Safety Net Foundation such records or information.
- I further certify that I am authorized to act for the institution for which I am signing.

\_\_\_\_\_  
**Facility's Authorized Representative Signature**

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
**Date Signed**

➤ Fax completed documents to **(866) 549-7239**