iLink™ Copay Savings Program Patient Application

Please complete all fields with black ink and fax form to **877.328.0135.**
Or mail to The iLink™ Copay Savings Program
2250 Perimeter Park Drive, Suite 300
Morrisville NC 27560

iLink™
CROSS-LINKING PROCEDURE

For fastest processing, please complete all *required fields.

Patient Information

*Name: (First)_____ (Last)_____ *DOB (mm/dd/yyyy):_____/_____/_____ *Gender: ◯Male ◯Female

*Address:_____ *City:_____ *State:_____ *ZIP Code:_____

Home Phone:(_____)_____-_____ Mobile Phone:(_____)_____-_____ Email:_____

Authorized Legal Representative: (First) _____ (Last) _____ Relationship to Patient:_____

Home Phone:(_____) _____-_____ Mobile Phone:(_____) _____-_____

Prescriber Information

If you are completing this section as a patient, please be sure to verify this information with your provider's office.

*Prescriber Name: (First)_____ (Last)_____ NPI #:_____

*Name of Treatment Site or Practice: _____

Facility Street Address:_____ City:_____ State:_____ ZIP Code:_____

Office Contact Name:(First)_____ (Last)_____ *Office Contact Phone: (_____) _____-_____ *Fax: (_____) _____-_____

Patient / Provider Signature for Terms & Conditions

Patient or Prescriber Signature:_____ Date of Signature:_____/_____/_____

By signing above, I verify that the information provided in this iLink™ Copay Savings Program Patient Application is complete and accurate to the best of my knowledge. I understand that Glaukos reserves the right at any time and for any reason, without notice, to modify this iLink™ Copay Savings Program Patient Application or to modify or discontinue any service or assistance provided through the Copay Savings Program. Finally, I authorize Glaukos and TrialCard, Inc., as my designated agents to use and disclose health information as necessary to verify the accuracy of any information provided, to provide reimbursement services through the iLink™ Copay Savings Program and (as applicable) to assess eligibility for copay assistance. If I am signing as the prescriber, I verify that my patient has provided a signed HIPAA Authorization that allows me to share protected health information with Glaukos for purposes of the iLink™ Copay Savings Program.