

Non-Invasive Test (NIT) Support Request

Eligible commercially insured patients and providers may complete this form together to enroll in the Non-Invasive Test Program, which offers diagnostic, insurance, and cost-assistance support—before or after MASH confirmation, or to confirm current fibrosis stage. Patient will need to submit proof of payment and required documentation to receive reimbursement.

HOW TO SUBMIT

*ASTERISK indicates required info | FAX ALL PAGES to 1-844-411-1177

CALL 1-877-219-7770 | VISIT MadrigalPatientSupport.com

1. PATIENT INFORMATION AND SIGNATURE

First name* _____ Last name* _____
Date of birth (MM/DD/YYYY)* _____ Gender* Male Female
Address* _____ Apt # _____ City* _____ State* _____ ZIP* _____
Phone* _____ Mobile Home | OK to leave detailed message? Yes No
Language (if not English) _____ Email* _____
Legal representative (if any) _____ Representative phone _____
Relationship to patient _____

I have read and consent to the Patient Authorization for Non-Invasive Test Support in Section 6.

SIGN
HERE*

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE

DATE*

IF SIGNED BY LEGAL REPRESENTATIVE Printed name _____ Date _____

2. PATIENT INSURANCE INFORMATION — Attach a copy of insurance card(s)

Insurance name _____ Policy # _____
Subscriber name _____ DOB _____ Group # _____

3. PRESCRIBER INFORMATION

First name* _____ Last name* _____
Specialty* _____ NPI #* _____
Address* _____ City* _____ State* _____ ZIP* _____
Primary office contact name* _____
Phone* _____ Ext _____ Fax* _____ Email _____

4. REQUEST FOR SUPPORT

I am seeking support to confirm my patient's insurance coverage of available non-invasive tests to confirm the presence of MASH and severity of liver fibrosis.

NIT CPT Code(s)/description to be used:

5. PRESCRIBER ATTESTATION

SIGN
HERE

PRESCRIBER SIGNATURE*

DATE*

Madrigal Non-Invasive Test Support Request: Prescriber Attestation

By submitting this form, I certify to the best of my knowledge that: (a) the person named on this form is my patient and that the information submitted is complete and accurate; (b) the above-referenced testing is necessary for this patient; (c) I have received the written authorization in accordance with applicable state and federal law (including the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ["HIPAA"]), to provide the health information regarding the patient on this form to Madrigal Patient Support®, or other third-party contractors working on behalf of Madrigal Patient Support for the purpose of requesting reimbursement support and information and to assess, if applicable, the patient's eligibility for patient assistance or other support programs related to the above-referenced testing; (d) the support requested on behalf of the patient may include benefits investigation (BI) and/or copay information. If applicable, I authorize Madrigal Patient Support to conduct a benefits investigation for my patient.

I consent to Madrigal Patient Support contacting me by fax, mail, or email to provide additional information to Madrigal Patient Support and understand that Madrigal Patient Support may revise, change, or terminate any program services at any time without notice to me.

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6. PATIENT AUTHORIZATION FOR NON-INVASIVE TEST SUPPORT

I authorize my physician(s) and their staff (together, “Healthcare Providers”), my health insurer, health plan or programs that provide me healthcare benefits (together, “Health Insurers”), to disclose my personal or other health information, which may include contact information, demographic information, financial information, and information related to my medical condition, treatments, and health insurance and benefits, to Madrigal Patient Support, and their respective partners, affiliates, subcontractors, and agents (together, “Madrigal”). I authorize Madrigal to receive, use, and share my information in order to provide me with access to the product, services, and programs described on this form, which may include the following:

- Working with my health insurance plan to understand or verify medical coverage for tests identified by my Healthcare Providers;
- Determining my eligibility for and facilitating enrollment into financial assistance services if I’m eligible, including copay assistance related to tests identified by my Healthcare Providers;

I understand that Madrigal may de-identify my information and use it in performing research, education, business analytics, marketing studies, or for other commercial purposes, including linkage with other de-identified information Madrigal receives from other sources. I understand that Madrigal may share my information, including identifiable health information, in order to de-identify it for these purposes and as needed to communicate with me by mail, telephone, or email, or, if I indicate my agreement and consent, by text.

Once disclosed to Madrigal, my personal information released under this Authorization may no longer be protected by state and federal law, including the Health Insurance Portability and Accountability Act (HIPAA). However, Madrigal will only use and share my personal information for the purposes stated on this Authorization or as otherwise permitted by law.

I understand that I do not have to sign this Authorization, but Madrigal will not be able to provide the services to me without it and I will not be able to enroll in Madrigal Patient Support. A decision by me not to sign this Authorization will not affect my ability to obtain medical treatment, payment for treatment, insurance coverage, access to health benefits or Madrigal products. However, I understand that my pharmacy may receive payment or other remuneration for disclosing my personal information and distributing marketing material pursuant to this Authorization.

This Authorization is valid for 18 months from the date support is last provided, or until my local state law requires expiration, or I revoke it earlier. I have the right to revoke (cancel) this Authorization at any time by submitting a written notice to: Madrigal Patient Support, P.O. Box 4640, Trenton, NJ 08650. If I revoke this Authorization, I will no longer be eligible for the services described. If a healthcare provider, health insurer, or Specialty Pharmacy is disclosing my personal information to Madrigal on an authorized, ongoing basis, my revocation will be effective with respect to such disclosing party when they receive notice of my revocation. My revocation will not impact uses and disclosures of my personal information that have already occurred in reliance on this Authorization.

More information on my privacy rights, including specific rights I may have as a resident of certain states can be found in Madrigal’s privacy policy (www.madrigalpharma.com/privacy).

I have a right to request a copy of this Authorization.



We’re here to help.

CALL 1-877-219-7770

VISIT MadrigalPatientSupport.com