



REBYOTA Patient Assistance Program (PAP) Appeal Form

This form is to be completed and signed by patients or their authorized representatives who were screened for additional financial assistance offerings through the REBYOTA Connect Program and were informed they do not qualify.

Use this form to file an appeal if you were informed that you do not qualify for the REBYOTA Patient Assistance Program by the REBYOTA Connect Program team. **Due to the urgency of this request, please fax this completed form to 1-877-778-7167, or ask your healthcare provider to fax the form to us on your behalf as soon as possible.**

If you have any questions, please contact REBYOTA Connect Monday through Friday, 8:00 AM – 8:00 PM EST at 1-877-732-9682.

After you complete and submit your appeal, you and your healthcare provider will be contacted by the REBYOTA Connect team to explain the outcome of your appeal.

PATIENT INFORMATION

Patient Name (full):		DOB: - -
Street Address:		Apt #:
City:	State:	Zip Code:

Please complete the table below by providing the most recent financial information for your household size including income and expense details.

CATEGORY	AMOUNT	CHECK ONE	
		Monthly	Annually
Net Income (after taxes):			
Rent/Mortgage			
Property taxes			
Car payment			
Utilities (electric, gas, water)			
Food			
Gas			
Student loans			
Unreimbursed medical expenses (excluding REBYOTA)			
Other (please specify)			

REBYOTA Connect reserves the right to verify accuracy of the information provided and may ask for more financial and insurance information.

By signing below, I attest that, to the best of my knowledge and belief, all information in the above referenced reported financial information section is accurate and complete.

Patient Name (printed):	
Patient Representative Name (printed, if applicable):	
Relationship to Patient (printed, if applicable):	
Signature of Patient or Representative:	Date:

