

`Bausch & Lomb, Inc.
Application for Silsoft Pediatric Patient Assistance Program

This program is designed to assist Eye Care Professional's pediatric patients and family with no source of medical device coverage through private insurance or from public assistance (i.e.: Medicaid, Medicare or charitable organizations) and fall below the U.S. Health and Human Services 2004 poverty guidelines, i.e. family of 4 annual income of less than \$18,850(For each additional person, add \$3,180).

Patient Name: _____

Reason for request: _____

Physician Name: _____

B&L Account number: _____

Office Address *: _____

Office phone number: _____

Requests will be accepted once per calendar quarter per patient. A new form must be filled out for every patient for each request. An original signature by the prescribing physician is required. This completed form must be returned by mail to fulfill the request. Please fax to:

Bausch & Lomb
Silsoft Pediatric Patient Assistance Program
Fax # 1-800-836-2757

A maximum of 2 lenses is allowed per patient per order. Any request above the specified limit will not be shipped. No substitutions allowed. Please allow 4-6 weeks for delivery.

Please in the parameter of the Silsoft lenses needed:

Diameter _____ Base Curve _____ Sphere Power + _____

Diameter _____ Base Curve _____ Sphere Power + _____

I have requested the above listed product from Bausch & Lomb Inc This product is to be given directly to the patient listed on this form and is not intended for sale or trade.

Signature of the prescribing physician
Signature stamps are not acceptable.

Date

*The office address will also serve as the shipping address.