

Bausch & Lomb Incorporated  
Application for Silsoft® Contact Lens Pediatric Patient Assistance Program

This program is designed to assist Eye Care Professionals' pediatric patients and families 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 year 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 mail to:

**Bausch & Lomb  
Silsoft Pediatric Patient Assistance Program  
P.O. Box 30450  
Rochester, NY 14603-0450**

A maximum of 2 lenses are 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 Incorporated. 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.

**Any questions, please contact Pete Sawycky at 1-800-252-8642 x 8076**