Request of Financial Assistance Information

Phone: 877-778-0318 Fax: 877-778-0399

Please print clearly.

PATIENT INFORMATION

First Name: _____ Last Name: _____ ☐ male ☐ female DOB: _____

Address, City, State, Zip: _____

Primary Phone Number: _____ ☐ Cell Secondary Phone Number: _____ ☐ Cell

Email Address: _____

PATIENT INFORMATION (continued)

What is the patient's medical condition/diagnosis relative to this application?

What drug/treatment is the patient being prescribed?

FUNDING CRITERIA QUALIFICATION

Number of people in patient's household (including patient): _____

What is patient's approximate annual gross household income? _____

Is patient a legal U.S. resident? ☐ Yes ☐ No Does patient have insurance coverage? ☐ Yes ☐ No

INSURANCE INFORMATION

Primary Health Insurance: _____ Primary Health Insurance Phone #: _____

Primary Health Insurance ID #: _____ Primary Health Insurance Group #: _____

***If different from above:*

Prescription Insurance: _____ Prescription Insurance Phone #: _____

Prescription Insurance ID #: _____ Prescription Insurance Group #: _____

PHYSICIAN INFORMATION

Physician's First & Last Name: _____ Contact Person: _____

Office Address, City, State, Zip: _____

Phone #: _____ Fax #: _____ NPI #: _____ DEA #: _____

If you are requesting information on someone's behalf, please complete the section below:

REQUESTER INFORMATION

Requester's First & Last Name: _____

Address, City, State, Zip: _____

Primary Phone Number: _____ ☐ Cell Alternate Phone Number: _____ ☐ Cell

Email Address: _____ Relationship to Patient: _____

AUTHORIZATION

Requester Signature: _____ Date: _____

Please PRINT patient's First & Last Name: _____