Request of Financial Assistance Information

Pharmacy Specialist
14155 Farmington rd.
Livonia, MI 48154

Fax to: 734-744-4847

Patient Information

Date:________________________ Date of Birth:____________________________ ☐ Male ☐ Female
First Name:______________________Middle Name: __________________ Last Name:_________________________________
Address:____ City:______________________ State:________ Zip:___________
Best Phone Number:__________________________________ Alternate Phone Number:_________________________________
Email Address: ______________________________________

Patient Information

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 US resident? ☐ Yes ☐ No Does patient have insurance coverage? ☐ Yes ☐ No

Insurance Information

Primary Insurance:______________________________ Primary Health Insurance Phone #:___________________________
Primary Health Insurance ID #:_____________________ Primary Health Insurance GROUP #:__________________________
Name of Prescription Insurance (if different than above):________________ Prescription Insurance Phone #:________________
Prescription Insurance ID #:_________________________ Prescription Insurance GROUP #:___________________________

Physician Information

Physician's Name:____Contact Person:____________________________________
Phone #:____________________________ Fax #: ____________________________ DEA #: ___________________________
Office Address:_______________________________________City:_______________________ State:___________ Zip:________

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

Requester Information

First Name:_________________________Middle Name: ___________________ Last Name:______________________________
Address:____ City:______________________ State:________ Zip:___________
Best Phone Number:__________________________________ Alternate Phone Number:_________________________________
Email Address: ______________________________________ Relationship to Patient: __________________________________

Authorization

Requester Signature ____Date ___________________

Please **Print** Patient Name ____

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