



Application for Co-Payment Assistance

275 Seventh Avenue, 22nd Floor, New York, NY 10001
866-55-COPAY (866-552-6729)

Step 1 – Personal Information

Patient Name

First Name _____ Last Name _____

Gender: Male Female Date of Birth: ____/____/____ (month/day/year)

Address _____

City _____ State _____ Zip Code _____

Home Phone () _____ Cell Phone () _____

Work Phone () _____

Email Address _____

Marital Status

Married Single Divorced Widow/Widower

Ethnic Origin (optional)

African American Asian Caucasian Hispanic Native American Other

US Veteran

Yes No

(if yes, do you have medical/prescription coverage through the VA?) Yes No

Disabled

Yes No

Social Security Number

Please provide your Social Security Number if you have one.

_____ - _____ - _____

If you are NOT a US Citizen, you must provide one of the following:

Green Card Number _____

A copy of the confirmation letter from the government stating that you have applied for a US Green Card.

Work Visa Number _____

Step 2 – Pharmacy / Infusion Information

Pharmacy

Not Applicable

PHARMACY Name _____

Contact _____ Position _____

Address _____

City _____ State _____ Zip Code _____

Business Phone () _____ Fax () _____

Specialty Pharmacy

Mail Order

Local

Infusion (IV) Provider

Not Applicable

INFUSION PROVIDER Name _____

Contact _____ Position _____

Address _____

City _____ State _____ Zip Code _____

Business Phone () _____ Fax () _____

If approved, we prefer to make payments directly to the provider (Doctor or Pharmacy) on the patient's behalf. Please check with your current provider to see if they will accept this assignment of benefits. If not, you should check with your insurance provider to find out if there is a mail order or specialty pharmacy that is considered an "in network" provider. Most mail order or specialty pharmacies will be able to bill the Foundation directly on your behalf.

Step 3 – Insurance Provider

Note: You must have Insurance Coverage for your cancer therapy in order to be eligible.

- Please Include a Photocopy of Your Insurance Card(s) Front and Back. If you have been working with a Reimbursement Support Agency and have been given a statement of your benefits, please include a copy.

Insurance Company - Primary

INSURANCE Company Name _____
 Address _____
 City _____ State _____ Zip Code _____
 Business Phone () _____ Fax () _____
 Subscriber ID (if applicable) _____ Group Number _____

What Type of Prescription Plan is it?

- Employer Private Medicare Part B Medicare Part D Medicare Advantage

If COBRA, date the coverage ends ____ / ____ / ____

Insurance Company - Secondary

INSURANCE Company Name _____
 Address _____
 City _____ State _____ Zip Code _____
 Business Phone () _____ Fax () _____
 Subscriber ID (if applicable) _____ Group Number _____

What Type of Prescription Plan is it?

- Employer Private Medicare Part B Medicare Part D Medicare Advantage

If COBRA, date the coverage ends ____ / ____ / ____

Step 3 (Continued) – Insurance Provider

Insurance Plan Details – Complete either A or B

(A) Employer, Private Plan or Medicare Advantage

- | | Primary | Secondary |
|---|----------|-----------|
| • What is your yearly deductible? <small>(the amount you pay before your insurance coverage begins)</small> | \$ _____ | \$ _____ |
| • What is your Out-of-Pocket Max? <small>(the total amount you pay before you have 100% coverage through insurance)</small> | \$ _____ | \$ _____ |
| • What is the Yearly Cap? <small>(the maximum amount your insurance will pay out for a calendar year at which time you are responsible for all medical expenses)</small> | \$ _____ | \$ _____ |
| • What is your Co-Payment? <small>(Co-Payment is a pre-set amount you pay for each prescription or office visit)</small> | \$ _____ | \$ _____ |
| • Co-Insurance Percentage? <small>(Co-Insurance is the percentage of the price of the drug or treatment you are responsible for)</small> | _____ % | _____ % |

(B) Medicare Part D – Standard Prescription Drug Plan

- Have you paid ALL of your \$275 deductible? Yes No
- To date, how much have you paid Out-of-Pocket toward your Medicare Part D coverage gap? \$ _____

If you are not sure, your pharmacist may be able to provide you with a pharmacy printout of what you have paid Out-of-Pocket to date.

Step 4 – Your Medications and Co-Payment Costs

List of Medications

Please list all the **CANCER** Medications you take **AND** the Co-Payment Costs

| Medication Name | MONTHLY Co-Pay Cost | Medical Benefit/Prescription Plan (Please Specify Benefit Type) |
|-----------------|---------------------|--|
| 1) _____ | \$ _____ | _____ |
| 2) _____ | \$ _____ | _____ |
| 3) _____ | \$ _____ | _____ |
| 4) _____ | \$ _____ | _____ |
| 5) _____ | \$ _____ | _____ |

If you are not sure what your insurance benefit will cover, you may want to get in touch with your Doctors office to see if they can verify your benefits or contact your insurance provider directly.

Step 5 – Information about Your Doctor

Prescribing Physician (Your Doctor)

First Name _____ Last Name _____

Address _____ Suite _____

City _____ State _____ Zip Code _____

Phone () _____ Fax () _____

Step 5 – (Continued) – Information about Your Doctor

Nurse or Patient Advocate who is Helping You Not Applicable

First Name _____ Last Name _____

Phone () _____ Fax () _____

If Address is different than your Doctor:

Address _____ Suite _____

City _____ State _____ Zip Code _____

Your Diagnosis

Breast Colorectal Lung Pancreatic

Step 6 – Dependents

How many people live in your household who can be claimed as a dependent on your tax return? (Including yourself – Example: You, Your Spouse and Your Child = 3)

Number of Dependents

| | |
|--|--|
| | |
|--|--|

Step 7 – Income Information

Checking Account

Attach a full copy of both you **and** your spouse's most recent Checking Account Statements

Step 7 – (Continued) – Income Information**Current YEARLY Household Income**

| Please provide your current YEARLY Income for Each | YOU | YOUR SPOUSE |
|--|-----|-------------|
| Salary <i>(before taxes)</i> | | |
| Social Security or Social Security Disability | | |
| Unemployment Income | | |
| Pension Income | | |
| Annuity Income | | |
| Minimum IRA Distribution | | |
| Alimony / Child Support | | |
| Interest / Dividends | | |
| Income Assistance <i>(Other Government Help)</i> | | |
| Net Business or Other Income | | |

Proof of Income **Please submit income verification for both you and your spouse.**

- A signed copy of your most recent US Federal Income Tax Return (IRS Form 1040, 1040A, 1040EZ)

 For Individuals who did not file an Income Tax Return last year, you must submit:

- A copy of your most recent Social Security/Disability Award Letter, Benefit Statement or monthly check
- A copy of your most recent paycheck/pension stub
- A copy of your Unemployment Check or Benefit Notification

Consent Information

I **give** the CancerCare Co-Payment Assistance Foundation (the "Foundation") and my doctor permission to:

- Check my information to make sure it is true and complete.
- Share my information with the pharmacists that may supply my medicine and the physician that prescribed my medicine.
- Share my information with the people helping with the Foundation.
- Contact me by mail or phone about CancerCare or the Foundation and about other programs or services that might interest me.

I **promise** that:

- All the information in this application, including all copies of documents proving my income, is true and complete.
- I am authorized to sign this application.
- I will contact the Foundation if any of the information about my prescription drug coverage, insurance status, pharmacy/infusion provider changes and/or my employment or salary changes.
- I do not receive any other financial assistance for the expenses that I have asked the Foundation to cover. This includes Medicaid, state drug assistance programs, and medical flexible spending accounts.
- I am not receiving other financial assistance from other co-payment assistance programs for the same medications.

I **understand** that the Foundation will only use my information to:

- Decide if I qualify to participate in the Foundation's co-payment assistance program.
- Administer or improve the Foundation.
- Communicate with insurance plans, including Medicare Part D plans.

I **understand** that I can call 1-866-552-6729 at anytime to:

- Withdraw from the Foundation.
- Cancel my permission to use my information and withdraw from the program.

I **understand** that:

- The Foundation is not in any way liable for the success or failure of my drug therapy or for any harm to my health that my medication may cause.
- The Foundation can ask for more information from me at any time.
- The Foundation can change or stop the program at any time for any reason with or without notice.

I **give** the Foundation permission to contact the person named below with follow-up questions about my application (this applies only if someone completed this application for you)

If a family member or someone helped you with this application and you want them to answer questions for you, please give us their name and phone number.

Helper's Name _____ Helper's Phone (____) _____

Signature of Applicant

X _____ Date _____