Mail or Fax Application to:

MaxCare
P.O. Box 16430
Oklahoma City OK 73113
Fax#: 405-213-1521

Patient Assistance Program

Participant Application Form

Patient Information

Full Name: ____________________ Social Security Number: ____________________

Mailing Address: ____________________

City: ____________________ State: ____________ ZIP: ____________

Phone Number: ____________________ Sex: ________ Birth Date: ____________

Physician Name: ____________________

Total Number of People Within Household (including Applicant): ____________________
Total Annual Income for Entire Household $____________________ (The current annual household income includes current annual salary, Social Security, unemployment insurance benefits and workers' compensation)
Please submit documentation to support the financial information
Attached is ☐ Most recent federal tax return (1040 form) ☐ W-2 form ☐ Other
We must receive proof of income to determine eligibility for assistance.
If you are required to file a federal tax return, please provide a signed copy. Proof of income may include documents such as: copy of most recent federal tax return, W-2 form(s), 1099 form, Social Security Award Letter or Check, or copy of three most recent pay stubs.
Does Applicant have health Insurance (Circle One): YES NO
Does it cover prescription drugs (Circle One): YES NO

Pharmacy Information

PharmacyName: ____________________

Address: ____________________

City: ____________________ State: ____________ ZIP: ____________

Phone Number: ____________________

Medications Requested

Drug Name & Strength: ____________________

Drug Name & Strength: ____________________

I hereby certify this information to be true and correct:

____

Signature of Applicant Date

For Office Use Only

☐ **Approved** ☐ **Denied**

Covidien Authorization Number: ____________________

Effective Date: ____________________ Term Date: ____________________

Phone Number: 405-525-5248 Toll Free 800-259-7765