Patient Assistance Program Application

Phone# (888)-432-5232 option # 3
Fax # (866)-212-2888

Physician Information:

Facility Name:_____
Physician's Name:_____
Office Address:_____
City/State/Zip Code:_____
Phone#:_____Fax #: _____
Tax ID #_____

Patient Information:

Patient Name:_____
Social Security Number:_____ Date of Birth:_____
Address:_____
City/State/Zip Code:_____
Phone #:_____Diagnosis_____

Primary
Insurance:_____Phone#:_____
ID#:_____Group:_____
Is Physician a preferred provider? Yes/ No If yes, ID#_____

Secondary
Insurance:_____Phone#:_____
ID#:_____ Group:_____
Is Physician a preferred provider? Yes/ No If yes, ID#_____

Income Information (a copy of the patient's 1040 tax form or Social Security Income Statement is required):

Annual Salary : $ _____Household Size:_____
Social Security : $_____Savings Balance: $_____
Other Assets: Real Estate/Stocks/Bonds $_____
Do you receive or have you applied for state assistance? Yes/No
If Yes, please specify what type and when you applied:_____
_____

I attest that the insurance and income information provided is complete and accurate. I consent to the release of confidential information, including the information on this form, by physician for the purpose of determining eligibility under the Patient Assistance Program. I authorize the assigned Apligraf Reimbursement Support Center Specialist to contact the insurance companies listed on this from with respect to determining eligibility under the Patient Assistance Program.

Patient's Signature :_____Date:_____

Physician's Signature :_____Date:_____