

Request of Financial Assistance Information

Please print clearly.**patient information**

patient: _____ ☐ male ☐ female **DOB:** _____
first name last name

address: _____ street city state zip

primary phone number: _____ ☐ cell **alternate 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 insurance: _____ **primary health insurance phone #:** _____

primary health insurance ID #: _____ **primary health insurance group #:** _____

prescription insurance: _____ **prescription insurance phone #:** _____
(if different from above)

prescription insurance ID #: _____ **prescription insurance group #:** _____

physician information

physician's name: _____ **contact person:** _____
first name last name first name last name

office address: _____ street city state zip

phone #: _____ **fax #:** _____ **NPI #:** _____ **DEA #:** _____

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

requester's name: _____ first name last name

address: _____ street city state zip

primary phone number: _____ ☐ cell **alternate phone number:** _____ ☐ cell

email address: _____ **relationship to patient:** _____

authorization

requester signature: _____ **date:** _____

please print patient name: _____ first name last name

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling 855-611-3399 or by emailing specialty@thriftywhite.com to obtain instructions as to the proper destruction of the transmitted material. Thank you.