

CANCER ASSOCIATION
824 Elmwood Park Boulevard, Room 240
New Orleans, Louisiana 70123-3342

FAX Line: (504) 733-0252
(SEND IN THIS FORM NOW)

TELEPHONE: 529-2273, 733-5539, **WITHIN** Metro New Orleans

TOLL FREE: 1-800-624-2039, **OUTSIDE** Metro New Orleans

PRINT OR TYPE LEGIBLY

CLINIC NUMBER: _____

PATIENT SERVICES ELIGIBILITY FORM

FOR THE PERIOD OF
JULY 1, 2009 THROUGH JUNE 30, 2010.

Patient's Name _____

Date of Birth: _____

Address _____

Apartment _____

City _____, LOUISIANA Zip _____ Parish _____

Social Security Number _____ Telephone Number _____

Email address, if applicable _____

Insurance Company _____

Does Your Insurance Company Pay for Outpatient Medications(s)? Yes _____ No _____

If Yes, What Percentage Does the Insurance Company Pay? _____ percent is paid by the company.

Policy Number _____ Effective Date _____

Medicare A # _____ Effective Date _____

Medicare B # _____ Effective Date _____

Medicare D # _____ Effective Date _____

Medicaid Number _____ Effective Date _____

INCOME: Please list Family member's name, **ALL SOURCES** of income **AND** include **AMOUNTS OF EACH SOURCE OF INCOME.**

	Family Member's Name	Amount of Income	Source of Income and/or Place of Employment
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

FAMILY INFORMATION: Please list **ALL** family members who are **LIVING WITH THE PATIENT** and include any information about any health problems of

those family members, their relationship to the patient, and ages of family member(s).

Family Member's Name, age, relationship to patient	Health Problem, if any
1. _____ _____	
2. _____ _____	
3. _____ _____	
4. _____ _____	
5. _____ _____	
6. _____ _____	

STATISTICAL INFORMATION: (TO BE USED FOR STATISTICAL REPORTS ONLY)

RACE _____ SEX _____ NATIONALITY _____

INFORMATION ABOUT THE PATIENT'S ILLNESS: PLEASE PRINT!

1. PHYSICIAN'S NAME _____

EMAIL _____

SECTION/DEPARTMENT _____

ADDRESS _____

DEPARTMENT'S TELEPHONE NUMBER(S) _____

DEPARTMENT'S FAX NUMBER(S) _____

2. DIAGNOSIS: **CANCER** OF _____

Stage	1	2	3	4	Metastasis to

3. PLACE OF TREATMENT _____

4. LIST OF MEDICATION(S) **LIST BOTH THE QUANTITY(IES) OF THE PRESCRIPTION(S) DISPENSED** (the number of pills the patient will need) **AND THE DOSAGE(S) OF THE MEDICATION(S) DISPENSED** *in a 30-day supply:*

5. Please list all areas for which assistance is being requested. **Please submit copies of all documents for which assistance is being requested.**

6. COLOSTOMY SIZE **RECOMMENDED BY YOUR PHYSICIAN** _____

7. BED/BLUE PADS USED? _____ Yes _____ No **50 per month provided by Cancer Association**
Size _____ S _____ M _____ L _____ XL

NAME OF PERSON SUPPLYING INFORMATION _____

RELATIONSHIP TO PATIENT _____

SIGNATURE** of Physician

Physician's Telephone Number and Extension

**By signing this form, I understand that the Cancer Association can provide only the generic equivalents (unless no generic equivalent is available from any of the pharmaceutical companies) and I hereby authorize the use of generic equivalents to be substituted for medications that are prescribed for the above-named patient and paid for by the Cancer Association

SIGNATURE of Referring Professional & Title

Referring Professional's Telephone Number and Extension

PRINTED NAME of Referring Professional

Referring Professional's Beeper Number

Referring Professional's Email Address

Referring Professional's FAX Number(s)

PRINTED Name of Patient

SIGNATURE of Patient

Today's Date (**PLEASE PRINT!!!**)

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A UNITED WAY AGENCY

Use this form ONLY IF:
patient requires the listed medication(s) of:
Phenytoin
Insulin for Injection
Syringes for Insulin Injection
and/or
Disposable needles # 21 or # 23.

Date : _____

To : Patricia Entrekin
Patient Services Coordinator

RE : Statement of Need of Medication as a Result of the Diagnosis of Cancer

Per the requirements of the Cancer Association, a United Way agency, this letter represents that the condition for which assistance with the medications and/or equipment listed below is requested **IS AS A RESULT OF CANCER.** The patient's name is _____, The patient suffers from _____, **WHICH IS A RESULT OF THE** _____ **CANCER.**

Please provide assistance for the following **CIRCLED** medications (strength and quantity to be dispensed in a 30-day supply, as well as directions on how the medication is to be taken) and/or equipment:

<u>GENERIC/CHEMICAL NAME</u>	<u>BRAND NAME</u>	<u>STRENGTH</u>	<u>QUANTITY</u>	<u>HOW TAKEN</u>
Phenytoin	Dilantin	_____	_____	_____
Insulin for Injection (Diabetes)	_____	_____	_____	_____
Syringes for Insulin Injection	_____	_____	_____	_____
Disposable needles, # 21 or # 23	_____	_____	_____	_____

If you need or require any additional information, please do not hesitate to call _____ at (_____) _____.

Sincerely,

Signature of Physician

PRINTED Name of Physician

Physician's Address

Physician's Telephone

(_____) _____