

Medication/Supply/Co-Pay Reimbursement Form for Cancer Treatment

Patient: Please list each medication or supply and attach pharmacy or insurance forms and receipt indicating the proof of payment. To be reimbursed for a co-payment please list and provide insurance form or a doctor receipt/billing and proof of payment. Please submit at least quarterly for payment.

Patient's Name:	
Address:	Phone:
Name of medications, supply, co-pay, etc. that are	directly related to patients cancer care:
Stage of Treatment being received: (circle one)	Active Chemotherapy/Radiation Treatment Continuous/Follow Up Treatment
Physician's Signature:	Date
Address:	Phone

Please return form to:

Putnam County Cancer Assistance Program
PO Box 165
Glandorf, OH 45848
Phone: 419-235-6487
Email: kathi@metalink.net

Email: kathi@metalink.net http://www.pccap.org

