There's Help & There's Hope!

CAP

Putnam County Cancer Assistance Program

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

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_____

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.

Please return form to:
The Putnam County Cancer Assistance Program
PO Box 165
Glandorf, OH 45848
419-235-6487
Email: kathi@metalink.net
http://www.pccap.org

United Way
United Way of Putnam County

PARTNER AGENCY