Non-Medical Aide Services Reimbursement Form
During Cancer Treatment

Patient's Name:_____

Address:_____Phone:_____

List of Dates for Non-Medical Aide Services:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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 date for Non-Medical Aide Services received during treatment. Please attach proof of payment for reimbursement or billing statement from the agency of your choice to be paid directly. Maximum payment to be paid is $500 per year.

Please return form to:
The Putnam County Cancer Assistance Program
1800 N Perry St, Suite 103
Ottawa, OH 45875
419-235-6487 / 419-538-6482
Fax: 419-943-1040
http://www.pccap.org
United Way Member Agency, United Way of Putnam County

Revised 06/2017

Please submit at least quarterly for payment.