



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 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
of Putnam County**

PARTNER AGENCY