



## 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 return form to:**  
The Putnam County Cancer Assistance Program  
1800 N Perry St, Suite 103  
Ottawa, OH 45875  
419-236-6487 / 419-538-6482  
Fax: 419-943-1040  
<http://www.pccap.org>  
United Way Member Agency, United Way of Putnam County

Revised 01/2017

**Please submit at least quarterly for payment.**