



Request of Financial Assistance

Single Point of Contact: 724-515-7053

Pharmacy: 866-213-9821

Please fill out and return to the following:

AccuServ Pharmacy

Attn: Funding Assistance

8731 Route 30

North Huntingdon, PA 15642

Or Fax to: 877-526-8823

1. Patient Information:

Patient: _____ Male / Female DOB: _____ Soc. Sec. # _____
First Name Last Name

Address: _____
Street City State Zip

Primary phone number: _____ Alternate phone number: _____

Email address: _____

2. Patient Information (Continued):

What is the patients' medical condition/diagnosis relative to this application?

What drug treatment/prescription is the patient being prescribed?

3. Funding Criteria Qualification:

Number of people in patient's household (including patient): _____

What is the patient's approximate annual gross household income? _____

Is patient a legal U.S. resident? yes no

Does patient have insurance coverage? yes no

4. Insurance Information:

Primary insurance: _____ Primary health insurance phone #: _____

Primary health insurance ID #: _____ Primary health insurance group #: _____

Prescription insurance: _____ Prescription insurance phone #: _____
(If different from above)

Prescription insurance ID #: _____ Prescription insurance group #: _____

5. Physician Information:

Physician name: _____ Contact name: _____
First Name Last Name First Name Last Name

Office address: _____
Street City State Zip

Phone #: _____ Fax #: _____ NPI #: _____ DEA #: _____

6. Requester Information:

If you are requesting on someone's behalf, please complete the section below:

Requester's name: _____
First Name Last Name

Address: _____
Street City State Zip

Primary phone #: _____ Alternate phone #: _____

Email address: _____ Relationship to patient: _____

7. Authorization:

Requester's signature: _____ Date: _____

Please print patient's name: _____
First Name Last Name

***IMPORTANT NOTICE:** this fax is intended to be delivered only to the named address. It contains materials that are confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named address you should not disseminate distribute or copy this fax. Please notify the sender immediately if you received this document in error and destroy this document immediately. Please fax completed form to AccuServ Pharmacy at 877-526-8823. Visit us at WWW.ACCUSERVPHARMACY.COM for online fillable forms.