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