Referral Form

Medication Assistance Program Coordinator
7165 Clearvista Drive
Indianapolis, IN 46256
Phone: 317-621-2409
Fax: 317-957-2823
Email: BHMAP@ecommunity.com

Today's Date: _____ Name of Primary Care Provider/Specialist: _____

E-mail address: _____

Patients Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Alternate Number: _____

Do you grant permission for the medication assistance coordinator to leave a detailed voicemail message including medication names? Yes_____ No_____

Date of Birth: _____Social Security Number: _____

Are you a United States citizen? Yes _____ No _____ Are you currently employed? Yes____ No _____

Did you file taxes last year **(if no please sign the 4506T form)?** Yes_____ No _____

Married: _____ Single: _____

Indicate the number of individuals in the household, including the patient: **Adults:** _____ **Children:** _____

In order to see if you are eligible to receive free medications from drug companies, please indicate the total **yearly** income for the **household** (Drug manufacturer will ask for copy of income information): _____

Do you receive any of the following?

Medicaid:	Yes_____	No_____
Medicare Part A and B:	Yes_____	No _____
If yes, Medicare number: _____Effective date for Part A: _____		
Medicare Part D:	Yes_____	No _____
Other prescription drug coverage:	Yes_____	No_____
Social Security / Disability:	Yes_____	No _____

Do you have drug allergies? Yes_____ No _____

If you answered yes, please list the medications you are allergic to and the reaction you experienced:
_____

I certify that the information I have provided above is accurate, complete, and true to the best of my knowledge and belief. I also understand that documents may be required to provide proof of income. If my financial situation or health insurance changes, my eligibility status will need to be reevaluated. I further understand that it is my responsibility to notify Community Health Network within ten days of any changes in my financial situation. I give permission to verify my income through the Department of Social Services, Social Security Administration, my employer, Veterans Administration and any other company, business, or organization from which I receive income.

By signing this referral form, I authorize representatives of **Community Health Network Medication Assistance Program** to ask necessary information of my health care providers, complete applications for medication assistance, sign application paperwork on my behalf, and share this information with pharmaceutical companies or assistance programs as required.

_____ _____

Signature of Patient Date