Community Health Network

REFERRAL FORM

Medication Assistance Program Coordinator
3500 S Lafountain Suite A217
Kokomo, IN 46902
P 765.776.3555
F 765.453.8080
KokomoONCMAP@eCommunity.com

Today's Date: _____ CHNw Caregiver assisting with form: _____

Patient's Name: _____ Date of Birth: _____

Address:_____

City/State/Zip Code: _____ Social Security Number: _____

Phone Number:_____ Alternate Number: _____

Do you grant permission for us to contact you by: ☐ Phone ☐ MyChart Message ☐ Email address: _____

Permission to leave detailed messages on voicemail? Yes_____ No_____

United States citizen? ☐ Yes ☐ No **Legal U.S. Resident?** ☐ Yes ☐ No **Indiana Resident?** ☐ Yes ☐ No

☐ Married ☐ Single ☐ Widowed

Indicate the number of individuals in the household, including spouse and all dependents as would be listed on a tax return: **Adults** _____ **Children:** _____

In order to see if you are eligible to receive free medications from drug companies, please indicate the total income for the **household:** _____ ☐ Yearly ☐ Monthly

Do you receive any of the following?

Medicaid/HIP/MHS: Yes_____ No _____ Application Pending _____

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. I 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 understand that it is my responsibility to notify Community Health Network within **ten days** of any changes in my financial situation and/or insurance status. 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** and its affiliates to ask necessary information of my health care providers, complete applications for prescription and medical coverage/assistance, and share this information with pharmaceutical companies and their representatives for assistance programs as required.

_____ _____

Signature of Patient Date