

REFERRAL FORM

Medication Assistance Program Coordinator 7979 Shadeland Ave Indianapolis, IN 46250 **P** 317.621.4294 **F** 317.957.2836 NorthOncMAP@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	d 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 household: \square Yearly \square Monthly	he total income for
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 ex	cperienced:
I certify that the information I have provided above is accurate, complete, and true to the best of my knowledge documents may be required to provide proof of income. If my financial situation or health insurance changes, will need to be reevaluated. I understand that it is my responsibility to notify Community Health Network with changes in my financial situation and/or insurance status. I give permission to verify my income through the Descrices, Social Security Administration, my employer, Veterans Administration and any other company, busin from which I receive income. By signing this referral form, I authorize representatives of Community Health Network and its affiliates to as information of my health care providers, complete applications for prescription and medical coverage/assistant information with pharmaceutical companies and their representatives for assistance programs as required.	, my eligibility status hin ten days of any Department of Social ness, or organization sk necessary