



Medication Assistance Program  
East Coordinator  
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Indianapolis, IN 46219  
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**REFERRAL FORM**

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