CHILDREN'S LEUKEMIA RESEARCH ASSOCIATION
CO-PAY ASSISTANCE PROGRAM

AVAILABILITY AS OF 1/15/18

.

APPLICATION INSTRUCTIONS

Read our Patient Aid Summary page in it's entirety and any other pages noted before sending in your application, as several changes have been made to our programs this year.

Applications are accepted by mail only, and will be not be processed if any information is missing. Attach a copy of your health insurance I.D. card(s). Make a copy of the application for your records.

Your treating facility must fill in Page 2 of the application, which is the only page we will accept by fax. When choosing this option, please write "To be Faxed" on that page and include it with your mailed application. Give your doctor's office Page 2 to fill in and fax to us.

Treating facilities filling out the entire application on behalf of the patient must submit them by mail only. Faxes of Page 2 apply to patients who are mailing their own applications, and have sent Page 2 to their doctor's office separately.

We can only apply the first-come/first-serve basis to your application after all completed pages have been received.

After mailing your application, allow three weeks for us to notify you by mail as to the status of your application.

After each claim is received and approved, allow up to 30 days from the date of this notice for our payment to be received. Our payment of claims over $500 may be split into separate checks in order to expedite their processing time.

A new application is required each year for further assistance from us.

Please feel free to contact us with any questions you may have by phone: 516-222-1944, fax: 516-222-0457 or email with Patient Aid Dept. in the subject line to: info@childrensleukemia.org. All information is kept strictly confidential and is not shared.

Children's Leukemia Research Association, Inc.
Patient Aid Department
585 Stewart Avenue, Suite 18
Garden City, NY 11530
Tel: 516-222-1944

CLRA CO-PAY ASSISTANCE APPLICATION FOR CALENDAR YEAR 2018

Check the program availability status first on the page prefacing the application and read the Application Instructions before mailing. Allow up to three weeks for reply.

FOR CLRA OFFICE USE ONLY	RECEIVED:	REPLIED:
	STATUS:	

PATIENT NAME: _____ DATE OF BIRTH:

WHICH OF OUR PROGRAM ARE YOU APPLYING FOR?

☐ Patient Aid Program — Waiting list only? ☐

☐ Matching Dollar Program — Waiting list only? ☐

IF DIFFERENT FROM THE PATIENT:

1. NAME OF PERSON TO REIMBURSE FOR MEDICAL BILLS: _____
   (Relationship to patient)
2. NAME OF PERSON WHO WILL BE SUBMITTING CLAIMS: _____
   (relationship to patient)

Treatment Information

WHICH OF OUR COVERED TREATMENTS AND SERVICES BELOW IS THE PATIENT SCHEDULED TO RECEIVE THIS YEAR?

Office Visit co-pays and charges for:

1. ☐ Check-ups / Consultations
2. ☐ Oral or IV Chemotherapy
3. ☐ Radiation Therapy
4. ☐ Post-Bone Marrow/Stem Cell Transplant Therapy
5. ☐ IVIG Immunoglobulin Therapy
6. ☐ Leukemia-related lab tests within your treating facility (not due to infection)
7. ☐ Leukemia-related lab tests co-pays and charges outside of your treating facility (not due to infection)

Prescriptions for:

8. ☐ Anti-nausea
9. ☐ Heparin
10. ☐ Vitamins
11. ☐ Minerals

Post-BMT Therapy prescriptions for:

12. ☐ Tacrolimus
13. ☐ Antibiotic, antiviral, antifungal

IS THE PATIENT TAKING ANY PRESCRIPTION DRUGS INTRAVENOUSLY AT HOME RELATED TO THEIR LEUKEMIA TREATMENT, AND IF SO, WHAT IS THE NAME OF THE MEDICATION AND THE CONDITION IT IS TREATING?

IS THERE ANYTHING THAT YOU ARE NOT CERTAIN IF WE COVER OR THAT YOU WOULD LIKE TO SEE US COVER?

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PATIENT NAME: _____ DATE OF BIRTH: _____

MEDICAL PROVIDERS CAN FAX THIS PAGE TO US AT: 516-222-0457

Dear Medical Provider: The above patient is applying for our Co-Pay Assistance Program. Please fill in this form as soon as possible, and return to patient or fax to us upon their request. Thank you.

TREATING PHYSICIAN'S NAME: _____

FACILITY NAME: _____

FACILITY BILLING ADDRESS: _____

_____

TYPE OF LEUKEMIA: _____ DATE OF DIAGNOSIS: _____

WILL THE PATIENT RECEIVE CHECK-UPS, TREATMENT AND/OR LAB TESTS FOR LEUKEMIA IN 2018? | Yes | | No

TREATING PHYSICIAN'S SIGNATURE: _____

DATE SIGNED: _____

TREATING PHYSICIAN'S LICENSE #: _____ TREATING PHYSICIAN'S DEA #: _____

Social Worker, Patient Navigator/Advocate or Facility Coordinator

NAME: _____ TITLE: _____

WILL YOU BE SUBMITTING CLAIMS TO US ON THE PATIENT'S BEHALF? ☐ Yes ☐ No

TEL#: _____ FAX#: _____ EMAIL: _____

FACILITY NAME: _____

FACILITY ADDRESS: _____

_____

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Patient Information

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

_____

TELEPHONE NO.: _____ EMAIL: _____

SOCIAL SECURITY#: _____ GENDER: ☐ MALE ☐ FEMALE

IF SOCIAL SECURITY # IS BLANK, FILL IN A OR B A. LEGAL RESIDENCY#: B. ITIN #:

IF DIFFERENT FROM ABOVE, NAME OF RESPONSIBLE PARTY FOR PAYING PATIENT'S MEDICAL BILLS:

NAME: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

_____

TELEPHONE NO.: _____ EMAIL: _____

Health Insurance Information

DOES THE PATIENT CURRENTLY HAVE HEALTHCARE INSURANCE IN EFFECT? ☐ Yes ☐ No

IF NO, WILL THE PATIENT BE APPLYING FOR HEALTHCARE INSURANCE EFFECTIVE IN 2018? ☐ Yes ☐ No

NAME OF PRIMARY HEALTH INSURANCE: _____

NAME OF SECONDARY HEALTH INSURANCE (IF ANY): _____

REMEMBER TO ATTACH COPIES OF ALL HEALTHCARE INSURANCE I.D. CARDS

Patient or Guardian Signature

I have read and agree to the Program Summary pages that I received with my application or obtained from the CLRA website. I hereby affirm that all of the information contained in this application is true, and that all required documents are attached. I further affirm that the patient's medical bills and pharmacy receipts submitted to CLRA will not be altered in any way, nor will duplicate claims be submitted to other agencies offering financial aid for the same services paid in full by CLRA. I understand that CLRA reserves the right to terminate any and all assistance to the patient upon periodic review of the case if necessary, and that all financial aid provided is always limited to the availability of CLRA's funds and is never guaranteed.

SIGNATURE: _____ DATE SIGNED: _____

PRINT NAME: _____