PATIENT AID PROGRAM MEDICAL PROVIDER FORM

Children's Leukemia RESEARCH ASSOCIATION

585 Stewart Avenue ◊ Suite 520 ◊ Garden City, New York 11530
Tel (516) 222-1944 ◊ Fax (516) 222-0457
Patient Aid Email: programs@childrensleukemia.org ◊ http://www.childrensleukemia.org

PATIENT NAME: _____ DATE OF BIRTH: _____

ATTN: Medical Provider

We provide financial assistance to children and adults with a blood cancer diagnosis.
The above patient is applying to our program for financial assistance.
Please complete this form as soon as possible and return to the patient/guardian.

Patient/guardian: Upload completed form into application portal BEFORE submitting for approval.

TREATING PHYSICIAN'S NAME: _____

FACILITY NAME: _____

FACILITY ADDRESS:

_____

_____

TYPE OF BLOOD CANCER: _____ DATE OF DIAGNOSIS: _____

SPECIFIC DIAGNOSIS: _____

TREATING PHYSICIAN'S
LICENSE NUMBER: _____ DEA: _____

TREATING PHYSICIAN'S SIGNATURE_____ DATE: _____

If applicable:

SOCIAL WORKER/PATIENT ADVOCATE NAME: _____

PHONE: _____ EMAIL ADDRESS: _____

IMPORTANT NOTE: Patients/Guardians must submit a completed Medical Provider Form with their application. All forms must be dated within 30 days of application submission.

All submitted applications and claims remain confidential and HIPAA compliant.