Thrifty White PHARMACY Specialty Services

Please fill out and return to the following:

Thrifty White Pharmacy
ATTN: SPECIALTY FUNDING ASSISTANCE
706 38th Street NW Unit A
Fargo, ND 58102
OR FAX TO: 855-423-8300

Request of Financial Assistance Information

Please print clearly.

patient information

patient: _____ (first name / last name) ☐ male ☐ female **DOB:** _____

address: _____ (street / city / state / zip)

primary phone number: _____ ☐ cell **alternate phone number:** _____ ☐ cell

email address: _____

patient information (continued)

What is the patient's medical condition/diagnosis relative to this application?

What drug/treatment is the patient being prescribed?

funding criteria qualification

Number of people in patient's household (including patient): _____

What is patient's approximate annual gross household income? _____

Is patient a legal U.S. resident? ☐ yes ☐ no **Does patient have insurance coverage?** ☐ yes ☐ no

insurance information

primary insurance: _____ **primary health insurance phone #:** _____

primary health insurance ID #: _____ **primary health insurance group #:** _____

prescription insurance: _____ (if different from above) **prescription insurance phone #:** _____

prescription insurance ID #: _____ **prescription insurance group #:** _____

physician information

physician's name: _____ (first name / last name) **contact person:** _____ (first name / last name)

office address: _____ (street / city / state / zip)

phone #: _____ **fax #:** _____ **NPI #:** _____ **DEA #:** _____

If you are requesting on someone's behalf, please complete the section below.

requester information

requester's name: _____ (first name / last name)

address: _____ (street / city / state / zip)

primary phone number: _____ ☐ cell **alternate phone number:** _____ ☐ cell

email address: _____ **relationship to patient:** _____

authorization

requester signature: _____ **date:** _____

please print patient name: _____ (first name / last name)