Thrifty White PHARMACY
Specialty Services

Please fill out and return to the following:

Request of Financial Assistance Information

Please print clearly.

patient information

patient: ______________________ ______________________ ☐ male ☐ female **DOB:** ____________
first name *last name*

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: ______________ ______________ **contact person:** ______________ ______________
first name *last name* *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*