CHILDREN'S LEUKEMIA RESEARCH ASSOCIATION
CO-PAY ASSISTANCE PROGRAM

APPLICATION INSTRUCTIONS

Please read Patient Aid Summary page in its entirety and all related pages prior to submitting your application.

Applications may be scanned, faxed, or mailed. Applications will 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.**
- **Medical care providers/treating facilities must complete page 2 of the application and forward it in any of the methods listed above.**

We can only apply first-come/first-serve basis to applications after all completed pages have been received. In the event additional information is required, you will be contacted. Please allow up to 30 days for properly completed application to be approved and processed.

A new application is required each year for further assistance.

Please feel free to contact us with any questions you may have.
Phone: 516-222-1944
Fax: 516-222-0457
Email: info@childrensleukemia.org

All information is confidential and in compliance with HIPPA

Patient Aid Department
585 Stewart Avenue, Suite 18
Garden City, NY 11530
Tel: 516-222-1944 | Fax: 516-222-9457
Email: info@childrensleukemia.org

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: ____

Health Insurance Information

TELEPHONE NO: ______________________ EMAIL: ______________________

DOES THE PATIENT HAVE HEALTHCARE INSURANCE IN EFFECT? ☐ YES ☐ NO

IF NO, WILL THE PATIENT BE APPLYING FOR HEALTHCARE INSURANCE EFFECTIVE THIS YEAR? ☐ YES ☐ NO

NAME OF PRIMARY HEALTH INSURANCE: ______________________

NAME OF SECONDARY HEALTH INSURANCE (IF ANY): ______________________

REMEMBER TO ATTACH COPIES OF ALL HEALTH 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 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 the 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.

PRINT NAME: ______________________

SIGNATURE: ______________________ DATE: ______________________

All submitted applications and claims remain confidential and HIPAA compliant.

MEDICAL PROVIDER MUST COMPLETE AND RETURN THIS PAGE OF THE APPLICATION

PATIENT NAME: ______________________ DATE OF BIRTH: ______________________

Medical Provider Information

Dear Medical Provider: The above patient is applying for our Patient Aid Program. Please fill in this form as soon as possible and return to patient or send to us upon request via fax at (516) 222-0457, email to info@childrensleukemia.org or US Mail to 585 Stewart Avenue, Suite 18; Garden City, New York 11530.

TREATING PHYSICIAN'S NAME: ______________________

FACILITY NAME: ______________________

FACILITY BILLING ADDRESS: ______________________

____

TYPE OF LEUKEMIA: ______________________ DATE OF DIAGNOSIS: ______________________

WILL PATIENT RECEIVE CHECK-UPS, TREATMENT AND/OR LAB TESTS FOR LEUKEMIA NEXT YEAR? ☐ YES ☐ NO

TREATING PHYSICIAN'S LICENSE NUMBER: ______________________ DEA: ______________________

TREATING PHYSICIAN'S SIGNATURE ______________________ DATE: ______________________

Social Worker, Patient Navigator/Advocate or Facility Coordinator

NAME: ______________________ TITLE: ______________________

WILL YOU BE SUBMITTING CLAIMS TO US ON THE PATIENT'S BEHALF? ☐ YES ☐ NO

PH: ______________________ FX: ______________________ EMAIL: ______________________

FACILITY NAME: ______________________

FACILITY ADDRESS: ______________________

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CLAIM FORM

PATIENT NAME: ________________ DATE OF BIRTH: ________________

Instructions: Enter information below from receipts and/or bills according to claim types. Prior to submission, make sure claims are within our covered series and guidelines.

PHARMACY - ***Check all that apply***

- ☐ IVIG
- ☐ ORAL CHEMO
- ☐ POST BMT THERAPY
- ☐ ANTI-NAUSEA
- ☐ NEUTROPENIA
- ☐ HEPARIN
- ☐ VIT/MIN

****Receipts for same drug can be consolidated on one line***

NAME OF DRUG	FILL DATE(S)	AMOUNT
	TOTAL PHARMACY	

TREATMENT AND LAB FACILITIES - ***Check all that apply***

- ☐ CO-PAY
- ☐ CHECK UP/CONSULT
- ☐ BLOOD TESTS
- ☐ IVIG
- ☐ IV CHEMO
- ☐ RADIATION
- ☐ OTHER DIAGNOSTIC/LAB TESTS

****Copay receipts per facility can be consolidated on one line***

FACILITY NAME	DATE(S) OF SERVICE	AMOUNT
	TOTAL TREATMENT & LAB FACILITIES	
	TOTAL CLAIMED PHARMACY + TREATMENT/LAB	

PAYMENT TO: ☐ **PATIENT** ☐ **GUARDIAN** **FIRST CLAIM?** ☐ **YES** ☐ **NO**

PLEASE NOTE: If $3,000 limit per year is NOT met on first claim, each subsequent claim requires the completion of a new claim form.