Children's Leukemia Research Association, Inc.

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.