Children's Leukemia Research Association, Inc.

MEDICAL PROVIDER MUST COMPLETE

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.

TREATING PHYSICIAN'S NAME: _____

FACILITY NAME: _____

FACILITY BILLING ADDRESS: _____

_____

TYPE OF LEUKEMIA: _____ DATE OF DIAGNOSIS: _____

SPECIFIC DIAGNOSIS: _____

TREATING PHYSICIAN'S
LICENSE NUMBER: _____ DEA: _____

TREATING PHYSICIAN'S SIGNATURE_____ DATE: _____

Children's Leukemia Research Association, Inc.

585 Stewart Avenue ◇ Suite 520 ◇ Garden City, New York 11530

Tel (516) 222-1944 ◇ Fax (516) 222-0457

http://www.childrensleukemia.org

Patient Aid Department Email: paco@childrensleukemia.org

All submitted applications and claims remain confidential and HIPAA compliant.