

Patient Assistance Program



MaxCare
P.O. Box 18204
Oklahoma City OK 73154

Fax#: 405-525-7523

Participant Application Form

Patient Information

Full Name: _____ Social Security Number: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ Sex _____ Birthdate: _____

Physician Name: _____

Household Size*: _____ Annual Household Income: _____

**Number of related persons living in home at this time.*

Does applicant have health insurance (Circle One): Yes No

Does it cover prescription drugs (Circle One): Yes No

Pharmacy Information

Pharmacy _____ Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____

Medications Requested

Drug Name & Strength: _____

Drug Name & Strength: _____

Drug Name & Strength: _____

Drug Name & Strength: _____

Signature

I hereby certify this information to be true and correct:

Signature of Applicant

Date

Approved

For Office Use Only

Denied

Mallinckrodt Authorization Number: _____

Effective Date: _____ Term Date: _____