



## 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: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Total Number of People Within Household (including Applicant): \_\_\_\_\_

Total Annual Income for Entire Household \$ \_\_\_\_\_ (The current annual household income includes current annual salary, Social Security, unemployment insurance benefits and workers' compensation)

Please submit documentation to support the financial information

Attached is  most recent federal tax return (1040 form)  W-2 form  other

We must receive proof of income to determine eligibility for assistance.

If you are required to file a federal tax return, please provide a signed copy. Proof of income may include documents such as: copy of most recent federal tax return, W-2 form(s), 1099 form, Social Security Award Letter or Check, or copy of three most recent pay stubs.

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: \_\_\_\_\_

I hereby certify this information to be true and correct:

Signature of Applicant \_\_\_\_\_

Date \_\_\_\_\_

**Approved**                      **For Office Use Only**                       **Denied**

Covidien Authorization Number: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Term Date: \_\_\_\_\_