



**Patient Assistance
Program Application**
Phone# (888)-432-5232 option # 3
Fax # (866)-212-2888

Physician Information:

Facility Name: _____
 Physician's Name: _____
 Office Address: _____
 City/State/Zip Code: _____
 Phone#: _____ Fax #: _____
 Tax ID #: _____

Patient Information:

Patient Name: _____
 Social Security Number: _____ Date of Birth: _____
 Address: _____
 City/State/Zip Code: _____
 Phone #: _____ Diagnosis _____

Primary
 Insurance: _____ Phone#: _____
 ID#: _____ Group: _____
 Is Physician a preferred provider? Yes/ No If yes, ID# _____

Secondary
 Insurance: _____ Phone#: _____
 ID#: _____ Group: _____
 Is Physician a preferred provider? Yes/ No If yes, ID# _____

Income Information (a copy of the patient's 1040 tax form or Social Security Income Statement is required):

Annual Salary : \$ _____ Household Size: _____
 Social Security : \$ _____ Savings Balance: \$ _____
 Other Assets: Real Estate/Stocks/Bonds \$ _____
 Do you receive or have you applied for state assistance? Yes/No
 If Yes, please specify what type and when you applied: _____

I attest that the insurance and income information provided is complete and accurate. I consent to the release of confidential information, including the information on this form, by physician for the purpose of determining eligibility under the Patient Assistance Program. I authorize the assigned Apligraf Reimbursement Support Center Specialist to contact the insurance companies listed on this form with respect to determining eligibility under the Patient Assistance Program.

Patient's Signature : _____ Date: _____

Physician's Signature : _____ Date: _____