040725 31731

PHARMACEUTICAL PATIENT ASSISTANCE PROGRAM - FINANCIAL DISCLOSURE FORM

CONFIDENTIAL

SECTION A: PATIENT INFORMATION

- **Patient Full Name:** Johnathan Michael Sterling
- **Date of Birth (MM/DD/YYYY):** 03 / 15 / 1968
- **Patient Address:** 123 Meadow Lane
- **City:** Anytown
- **State:** CA **Zip Code:** 90210
- **Phone Number:** (555) 123 - 4567
- **Email Address:** j.sterling@emailprovider.net

SECTION B: PRESCRIBING PHYSICIAN INFORMATION

- **Physician Full Name:** Dr. Evelyn Reed
- **NPI Number:** 1234567890
- **Clinic/Hospital Name:** Anytown General Hospital
- **Address:** 456 Health Plaza
- **City:** Anytown
- **State:** CA **Zip Code:** 90211
- **Phone Number:** (555) 987 - 6543
- **Fax Number:** (555) 987 - 6544

SECTION C: MEDICATION INFORMATION

- **Prescribed Medication:** CardiaCare XR
- **Dosage:** 100mg **Frequency:** Once Daily
- **NDC Number (if known):** 98765-4321-01
- **Diagnosis Code (ICD-10):** I10 (Essential Hypertension)
- **Date Prescription Written (MM/DD/YYYY):** 10 / 28 / 2023

SECTION D: INSURANCE INFORMATION

- **Primary Insurance Provider:** Blue Shield United
- **Policy/Group Number:** GRP789XYZ
- **Member ID:** MBR123456789
- **Is patient covered by Medicare Part D?** ( ) Yes (X) No
- **Is patient covered by Medicaid?** ( ) Yes (X) No
- **Secondary Insurance (if applicable):** N/A
- **Policy/Group Number: _**
- **Member ID: _**

SECTION E: FINANCIAL INFORMATION (Attach Proof of Income - Last 2 Pay Stubs or Tax Return)

- **Total Household Annual Income (Gross):** $ 48,500
- **Number of Dependents in Household:** 2
- **Source of Income:**
  - (X) Employment
  - ( ) Social Security / Disability
  - ( ) Pension / Retirement
  - ( ) Other: ____
- **Have you applied for other assistance programs?** (X) Yes ( ) No
  - If yes, please list: State Prescription Assistance Program (SPAP)

SECTION F: AUTHORIZATION AND SIGNATURE

I certify that the information provided on this form is true and accurate to the best of my knowledge. I authorize my physician, pharmacy, and insurance company to release my medical and billing information to **MediCorp Pharma** and its agents for the purpose of determining eligibility for the Patient Assistance Program. I understand that this authorization is voluntary and that I may revoke it at any time by writing to **MediCorp Pharma, 1 Pharma Drive, Innovation City, ST 54321**.

- **Patient/Guardian Signature:** *Johnathan M. Sterling* (Signature Placeholder)
- **Date:** 11 / 02 / 2023

For Internal Use Only:

- **Application Received Date: ___**
- **Eligibility Status:** ( ) Approved ( ) Denied ( ) Pending Information
- **Assigned Case Manager: _**

- **Approval Period:** From ___ To ___

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