FINANCIAL ADVOCACY NETWORK

Resources & Tools for the Multidisciplinary Team

Patient Assistance Checklist for Medicare & Supplemental Insurance Patients

- ❑ I have received the chemotherapy order written by the physician?
- ❑ I have verified the patient's insurance coverage?
- ❑ I have verified that the drug(s) are indicated for the patient's diagnosis?
- ❑ I have obtained prior authorization, if needed?
- ❑ I have identified the patient's responsibility (an estimate in dollars) for treatment costs?
  If there is no patient responsibility, treatment is started. If there is patient responsibility, continue through this form.
- ❑ I have met with the patient to assess his or her ability to pay for treatment?
- ❑ Based on this meeting, does patient need drug replacement?
  ❑ YES ❑ NO
- ❑ If yes, is a replacement drug program available? (Note: an appeal must to be made to receive drugs.)
  ❑YES ❑ NO
  If yes, identify drug and program:

_____

❑Does the patient qualify for this program?
❑YES ❑NO
If no, state reason(s) why:

_____

- ❑ If yes, I have completed all the necessary forms and paperwork for the drug replacement program.
  ❑ YES ❑ NO
  If no, state reasons why:

_____

ACCC
Association of Community Cancer Centers

❑ Does the patient need drug(s) that are not available through a drug replacement program?
❑YES ❑ NO
If yes, identify which drugs:

_____

❑ Is Foundation funding assistance available for any of these drug(s) or to help with other treatment-related costs?
❑ YES ❑ NO
If yes, identify Foundation(s) and drug(s):

_____

❑ I have completed all the necessary forms and paperwork for these Foundation funding program(s).
❑ YES ❑ NO
If no, state reasons why:

_____

❑ I have sent in EOB or other paperwork necessary to verify the amount the Foundation will pay towards the drug(s).
❑ YES ❑ NO
If no, state reasons why:

_____

❑ Is there a balance or money owed related to treatment?
❑ YES ❑ NO
If yes, identify balance:

_____

❑ If yes, I have worked with the patient and family to create a payment plan for the balance of his or her treatment costs.
❑ YES ❑ NO