Cancer Association
OF MERCER COUNTY, INC.

218 South Main Street, Suite A . PO BOX 624 . Celina, Ohio 45822
Phone / FAX: 419.584.0014

APPLICATION FOR ASSISTANCE

NAME ______________________________ SSN ______________

ADDRESS ____

CITY ______________ STATE ________ ZIP __________ PHONE ______________

EMAIL ADDRESS ____

DATE OF SERVICE (Today's Date) ______________ DATE OF BIRTH ______________

TYPE OF CANCER ______________________ DATE DIAGNOSED ____________

EMPLOYER ____

SPOUSE'S NAME ____________________ SPOUSE'S EMPLOYER ______________

CONTACT PERSON ______________________________ PHONE ______________

INSURANCE OR OTHER MEDICAL BENEFITS AVAILABLE

GROUP OR PRIVATE INSURANCE COMPANY NAME ______________________

MEDICARE (GIVE NUMBER) ______________________________________

MEDICAID (GIVE NUMBER) ______________________________________

ATTENDING PHYSICIAN ____

ADDRESS ____

CITY ______________ STATE ________ ZIP __________ PHONE ______________

How did you hear about CAMC? __________________________________

I find the above information to be correct and understand that any payment made by the CAMC will be made only on amounts due after insurance and other benefits, which are available to me, have been credited.

______________________________ ______________

signature of patient or representative date

Cancer Association
OF MERCER COUNTY, INC.

218 South Main Street, Suite A . PO BOX 624 . Celina, Ohio 45822
Phone / FAX: 419.584.0014

PHYSICIANS DOCUMENTED PROOF OF ILLNESS

Patient's Name: ____

IS CURRENTLY UNDER MY CARE FOR

Type of Cancer:____

Physician's Signature_____________________________ Date____________

Physician's Printed Name________________________________

Physician's address_______________________________________

Physician's Phone Number_________________________________

We assist with mileage reimbursement, doctor co-pays, prescription medicines, wigs, ostomy supplies, Ensure & Boost, medical equipment, prostheses and more.

All receipts and mileage need to be submitted within 3 months time.

Limits apply to each client and are determined on a case by case basis.

Cancer Association
OF MERCER COUNTY, INC.

218 South Main Street, Suite A . PO BOX 624 . Celina, Ohio 45822
Phone / FAX: 419.584.0014

MILEAGE ACCOUNTING FORM

In order to get reimbursement, this mileage accounting form must be filled out completely by the driver and signed by an authorized person at the treatment center.
It can be mailed to or dropped off at: Cancer Association of Mercer County
218 South Main Street, Suite A . PO BOX 624 . Celina, Ohio 45822
Phone / FAX: 419.584.0014
Email: camc@bright.net
CAMC office hours are 9:30 a.m. - 4:30 p.m. Mondays - Thursdays.

Driver's Name ______________________________

Patient's Name ______________________________

Treatment Center Name ______________________________

Treatment Center Address ______________________________

____

Miles (per round trip) ______________________________

Treatment Dates ______________________________

SIGNATURE of nurse/attendee at center ______________________________

PRINTED NAME of nurse/attendee at treatment center ______________________________

PHONE NUMBER of nurse/attendee at treatment center ______________________________

ALL MILEAGE NEEDS TO BE TURNED IN WITHIN 3 MONTHS OF TREATMENT DATE.

OFFICE USE

Page _____ **of** _____

Transportation ______________________________

Dress ______________________________

Medications ______________________________

Co-Pays ______________________________

Wig / Hat / Turban ______________________________

Nutritional Supplements ______________________________

Prostheses / Ostomy supplies ______________________________

Miscellaneous Expenses ______________________________

Total Reimbursed ______________________________

Check Number ______________________________

Date Reimbursed ______________________________