PAN Foundation

Improving access.
Transforming health.

Direct Member Reimbursement Form: Medications and Treatments

PAN Foundation **grant recipients** can submit covered expenses for reimbursement using this form and proof of purchase. This form cannot be used for travel or premium reimbursement. For travel and premium claims, call us at 866-866-316-7263, Mon – Fri, 9am–5:30pm ET.

Providers and pharmacies cannot use this form to submit for payment.

Instructions:

1. **Complete all fields, and sign and date this DMR form.** This form can be signed by either the patient or the patient's caregiver completing the form on the patient's behalf.
2. **Expenses related to medications or supplies must include one of the following:**
    a. EOB (explanation of benefits) direct from the insurance carrier(s), which must include: Insurance carrier name, insurance carrier logo, insurance carrier contact information, date of service (DOS), procedure/NDC, allowable insurance amount, amount paid by the insurance, and copay amount due.
    b. Prescription receipt label, which must include: Pharmacy name and address, pharmacy phone number, medication name, dosage, provider, directions, pharmacist initials, date of service (DOS), refills, patient name, patient address, prescription number, quantity dispensed, copay amount due, expiration date, and prescriber.
    c. Photograph of the prescription label, which must include: Pharmacy name and address, pharmacy phone number, medication name, dosage, provider, directions, pharmacist initials, date of service (DOS), refills, patient name, patient address, prescription number, quantity dispensed, copay amount due, expiration date, and prescriber.
3. **Proof of payment is required for expenses and must include the following:**
    a. Register receipt showing amount and pharmacy transaction number, transaction date, pharmacy name, pharmacy address, and phone number.
    b. EOB showing the annual total out of pocket cost, which includes the date of service.
4. **Fax, mail, or upload the signed and completed DMR form with the required documents:**
    a. Fax: 844-726-4728
    b. Mailing address: PAN Foundation, PO Box 2955, Clinton, IA 52733
    c. Online via the PAN portal: panapply.org. Note: You must be logged in to the portal to submit via the portal. If you need assistance setting up a portal account, view our guides online at panfoundation.org/guides, or call us at 866-316-7263, Mon – Fri, 9am–5:30pm ET.

Payment made payable to the patient will be issued in the form of a paper check within 10 business days of receipt of completed forms.

Questions? Contact PAN at 866-316-7263, Monday - Friday, 9:00am to 5:30pm Eastern Time

Patient Information *Required fields

First name* _____ Last name* _____

Date of birth* (MM/DD/YYYY) _____ PAN ID number* _____

Group number* _____ Patient phone number* _____

Patient street address* _____

City* _____ State* _____ Zip* _____

Medication information

Name of your medication(s) * _____

_____

Where did you receive your medication(s)?* (please check one)

☐ Physician office ☐ Pharmacy (pickup/mail order) ☐ Outpatient (facility/hospital)

List of date(s) you received your medication(s) (MM/DD/YYYY) *

_____

Total requested reimbursement amount: * _____

Have you opted into the Medicare Payment Plan, which allows you to spread your out of pocket prescription drug costs over the calendar year in monthly payments, rather than paying the full amount at the pharmacy upfront? **No** ☐ **Yes** ☐

If yes, please provide your total annual out-of-pocket cost as shown on your Explanation of Benefits (EOB), along with a copy of the EOB displaying this amount. Be sure to use the original date of service for the reimbursement to avoid delays in processing your DMR form. If yes, **Total cost:** * _____

REMINDER: Did you attach the required expense documentation?

Declaration:

I attest and certify under penalty of law to the Patient Access Network Foundation that the information provided on this form is complete and accurate. I further understand that reported information may be verified by an audit as deemed necessary by the Foundation. I understand that assistance will terminate if the Foundation becomes aware of any fraudulent activity relating to the assistance provided by the Foundation. I understand that assistance may be limited to the terms and conditions established by the Foundation and that the Foundation reserves the right at any time, or for any reason, and without notice to (i) modify this form, (ii) modify or discontinue any or all of the programs and the related eligibility criteria, or (iii) terminate assistance. I authorize the Foundation and its employees, third party administrators, agents and other representatives to obtain information from my healthcare providers, insurance coverage information from my employer or insurance company(ies) as necessary to complete the reimbursement process or to verify the accuracy of any information provided with this form.

Patient attestation: * ☐ I agree with all attestations presented above.

Patient signature* _____ Date* _____

Caregiver attestation: * ☐ I am attesting that I have informed the patient of all the above information and that the patient agrees with it or that I have the authority to make decisions on behalf of the patient and that I agree to the above attestations on behalf of the patient.

Caregiver first name* _____ Caregiver last name* _____

Caregiver signature* _____ Date* _____