Avella Specialty Pharmacy

Financial Assistance Form

Please fill out and fax or email to:

Avella of Deer Valley, Inc.
23620 N. 20th Dr. #12
Phoenix, AZ 85085
Fax: (877) 546-5780
Email: pafunding@avella.com

1: Patient Information

Patient Name: _____ **Birthdate:** _____ **Sex:** ○Male ○Female **Height:** _____ **Weight:** _____ ○lbs. ○kg.

Soc. Sec. #: _____ **Preferred Phone:** _____ **Known Allergies:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Alternate Caregiver Name: _____ **Preferred Phone:** _____

Patient's medical diagnosis as it relates to this application:

What medications or treatments are being prescribed?

2. Funding Criteria

Number of people in patient's household *(including patient)*: _____ **Patient's annual gross household income:** _____ **/ year**

Is patient a legal U.S. resident? ○Yes ○No **Does patient have insurance coverage?** *(if "yes", fill out insurance information below)* ○Yes ○No

3. Insurance Information

Primary Health Insurance:

Insurance Name: _____
Phone Number: _____
Insurance ID#: _____
Group #: _____

Prescription Insurance *(if different from Primary Insurance)*:

Insurance Name: _____
Phone Number: _____
Insurance ID#: _____
Group #: _____

4: Prescriber Information

Provider Name:

☐ _____

DEA#: _____ **NPI#:** _____

Key Contact Info:

Name: _____
Phone: _____
Email: _____

Practice Info:

Practice Name: _____
Address: _____
City: _____ **State:** _____
Zip: _____ **Tax ID#:** _____
Phone: _____ **Fax:** _____

If you are requesting on behalf of someone else, please complete the section below:

Name: _____ **Relationship to patient:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Email: _____ **Preferred Phone:** _____

5. Authorization

Requester Signature: _____ **Date:** _____

PRINT patient's name: _____