[To be filled out by the Patient, Caregiver, Pharmacy or Patient Advocate]

Musella Foundation

Patient Co-Pay Assistance Program

Claim Form *version 15.1*

Patient Name: _____ DOB:_____

Patient Address: _____

Patient City / State / Zip _____

Last 4 digits of SSN: _____ Phone: _____

We can consider only your out of pocket expenses for these treatments: (Check our website for any changes): **Avastin, Lomustine, Optune and Temodar (or generics of these)** that were dispensed during your approved claim period. You may submit as many claims as needed up to the total amount of your grant. Items with a * are required!

*Date Dispensed	*Treatment Name	Charge (optional)	Insurance Paid (optional)	*Your Out of Pocket Cost
		$	$	$

*Total out of pocket expenses: $ _____

IF approved, whom should we make out the check to:

Name: _____

Address: _____

City State Zip: _____

Direct Phone**: _____ Contact Person: _____**

Attach a copy of the: Insurance Explanation of Benefits or receipts for charges you paid. Circle the numbers, treatment name and dates you use!

Please **UPLOAD** completed form and receipt(s) to us at: **braintumorcopays.org**

Or Fax to 1-877-869-2333