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

Musella Foundation

Patient Co-Pay Assistance Program

Claim Form *version 18*

Patient Name: _____ DOB:_____

Patient Address: _____

Patient City / State / Zip _____

Last 4 digits of SSN: _____ Phone: _____

We can consider only out of pocket expenses for Avastin, Lomustine, Modeyso, Optune, Procarbazine, Temodar and Vincristine (or generics of these) dispensed during your approved claim period. Check our website for changes. 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