Musella Foundation
Patient Co-Pay Assistance Program
Application Form For Patients
version 11

READ THIS!

1. Check our website at **braintumorcopays.org** to see if we have funding, to check for a newer version of this application and any recent changes to the income qualification or treatments covered before submitting the application!   Old versions of the application will be rejected.

2. Applications MUST be typed. We can no longer accept hand written applications because there were too many errors interpreting handwriting. If you can not type into the form then contact us before submitting it.

3. We respond only by email. Make sure to check your spam folder. If you do not get a reply within 2 days call us at 1-855-426-2672. If you choose not to give us an email address, call us for the status 2 days after sending the application.

4. The first 2 pages of your most recent tax return is the best proof of income. **If you do not file taxes**, enclose a letter saying you do not file taxes, and list your sources of income last year and send whatever proof you have and it will be considered – but it may slow down the process.

5. IF it is difficult to get the doctor to fill out the “Certification form for physicians”, you can send us a copy of your pathology report instead.

Overview

This program can help pay for your treatment, if you qualify and if we have funds remaining. There is never any cost to you. You can use any doctors and treatments you like (but we only cover the treatments listed on our website) —we never will ask you to switch. Visit our website http://BrainTumorCoPays.org to see the covered list of treatments and to learn more.

First, let's see if you qualify. To qualify for the program, you **must** be able to answer "**yes**" to the following questions:

1. Do you have a **primary (Not metastatic), GRADE 3 or 4, malignant brain tumor**?
2. Do you have **health insurance** (Medicare or another type) that pays for at least a portion of your treatment bill?
3. Financial need: Is your family income below 5 times (500%) the federal poverty level? (See our website for current levels – the chart below is as of Jan 2020).

If you answered "yes" to all of these questions, you are eligible to apply. Acceptance into the program is on a first-come-first-served basis (of completed, typed, applications), until we run out of money. If you are accepted, we will cover up to $5,000 of your share of the cost of covered treatments used to treat your brain tumor over a 12-month period: 3 months before your date of application and 9 months after. You can reapply for another grant when your grant expires. To apply for a renewal, send this entire application again on or after the expiration date of the original grant, but you do not need to include the certification form for physicians.

CLAIMS: We can pay the pharmacy directly OR reimburse the patient. We can not pay until the treatment is dispensed. We do paper claims only so there is NO electronic billing information. You must use our claim form which is in this packet, and also send the receipt. The receipt must show at least the patient's name, treatment name, date dispensed and amount the patient has to pay.

Persons in Family or Household	Max. Family Income Last Year
1	$63,800
2	$86,200
3	$108,600
4	$131,000
5	$153,400
6	$175,800
7	$198,200

Who is submitting this form:

☐ **Patient (or Family / Friends)**

☐ **Pharmacy Staff**

☐ **Provider Staff**

☐ **Manufacturer's Patient Assistance Program**

IF the person submitting this form is NOT listed on the next page, give us your contact information:

Name: ____

Phone: ____

Email: ____

Please type into this form on your computer then print it to sign and fax.
We will notify you by email within 3 business days. If you do not hear back from us in 3 days, or if this is an emergency, call us!

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

Patient Copayment Assistance Program Application

Version 11

Details at http://braintumorcopays.org

Patient:

First Name: ________________ MI:____ Last Name: __________________________

Address: ____

City: __________________________State (2 letters): ______ Zip: _____________

Phone: ________________________ Email: _______________________________

Sex: __ Male __ Female Date of Birth _______________________

Social Security Number (last 4 digits) ________

Alternate Contact Person: (may be relative, friend, patient advocate)

This is required. We cannot approve application without this!

First Name: ______________ MI: ______ Last Name: _______________________

Address: ____

City: _________________ State (2 letters): ______ Zip: _____________

Phone: __________________________ Email: _______________________________

Relation to Patient: ______________

Prescribing Doctor:

First Name: _______________ Last Name: ________________ Degree(s): ________

Hospital / Facility: ____

Address: ____

City: _______________________ State (2 letters): _____ Zip: ________________

Phone: ___________________________

Qualifications: DO NOT APPLY IF YOU ANSWER NO TO ANY QUESTION!

Does the patient have a **PRIMARY GRADE 3 or 4 Malignant Brain Tumor**:
__ Yes __ No

What Specific GRADE and TYPE of Tumor :___________________________________

Does the patient have **health insurance**? __ Yes __ No

Is the patient a **resident** of the United States? __ Yes __ No

# of people in household? _______ **Gross Family Income** Last Year: $ ___________

Special Circumstances? (Like loss of job / disability?): __________________________

By signing, I certify that:

- all of the responses are complete and accurate to the best of your knowledge
- that you consent to allowing the Musella Foundation contact all of the people named in this application for reasons of processing this application and processing claims?
- that you will not request reimbursement for expenses covered by another insurance company or assistance program?
- If you included an email address – you consent to us sending unencrypted email to that address. IF YOU DO NOT CONSENT THEN DO NOT GIVE US AN EMAIL ADDRESS!

Print Name: ____

Signature: ____ Date: _________
(Patient should sign – but if unable to or under 18 years old, the contact person may sign)

Attach a copy of:

1. **Your most recent Federal Tax Return (First 2 pages only).**
2. **Your insurance card, front and back**

How did you hear about our program? **Circle all that apply**
doctor | nurse | patient advocate | pharmacist | support group | online support group | friends
Google | Bing | Yahoo | Other Search Engine | NeedyMeds.org | Virtualtrials.com |

Other: (specify): ____

Please fax completed form to us at: 1-877-869-2333

If you have any questions, call us toll free at 1-855-426-2672

Or Mail to:

Musella Foundation
1100 Peninsula Blvd
Hewlett, NY 11557

[Ask your doctor to fill this out for you]

Musella Foundation

Patient Co-Pay Assistance Program

Certification Form For Physicians

Version 11

Patient Name: ___________________________________ DOB: ______________

Patient Address: ____

Patient City / State / Zip ____

Patient Phone: ____

The above-named patient is applying to our patient co-payment assistance program and has given permission for you to supply the following information so that we can help with the costs of the treatments you prescribe.

1. **Does this patient have a Primary (Not Metastatic), Grade 3 or 4 Malignant Brain Tumors? __Yes __ No**
2. **What SPECIFIC TYPE of Brain Tumor: (circle tumor or write it in if not listed!): Glioblastoma Multiforme, Anaplastic Astrocytoma, High Grade Oligodendroglioma, DIPG, DMG, Medulloblastoma,**

   OTHER:____

Dr. Name (Print or use stamp):____

Hospital / Clinic Name:____

Dr. Address ____

Dr. City / State / Zip / Phone: ____

Signed: ____________________________________ Date: _______________

Please fax completed form to us at: 1-877-869-2333
Or Upload at braintumorcopays.org
If you have any questions, call us toll free at 1-855-426-2672
[A copy of the pathology report may be used instead of this form – if it is clear that the tumor is a primary malignant brain tumor]

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

Musella Foundation
Patient Co-Pay Assistance Program
Claim Form *version 11*

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, Gliadel, 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 **fax** completed form to us at: **1-877-869-2333**

Or Upload at braintumorcopays.org

Musella Foundation

Patient Co-Pay Assistance Program

Check List

Keep this page as a record to make sure you sent all of the information. If you do not hear from us within 2 business days after you fax (or 2 weeks after mailing) all required documents, or if this is an emergency, **contact us toll free at 1-855-426-2672**. NOTE that we only notify you by email. If you choose not to give us an email address, contact us 2 days after sending the application!

Required Item	Date Sent
Application Form	
Doctor's Certification	
Insurance Card (Front and Back)	
Proof of Income	

You may (but do not have to) send in the Claim form and explanation of benefits at the same time as the application. Or you can wait until we approve you.

To fill out this form: open it on your computer and type in your responses, then print it, sign it and send it to us.

The best way to send it is to upload it to our website. Go to braintumorcopays.org and click UPLOAD. This requires that you can scan the documents into one PDF file.

If you can't scan it – then send via fax to: 1-877-869-2333

If the above fax doesn't work, use our alternate fax: 516-295-2870 – but this may add a day or two to processing.