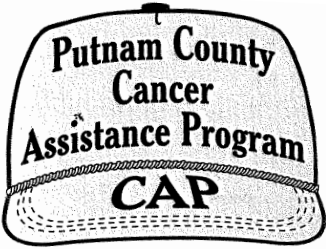


**PUTNAM COUNTY HOMECARE & HOSPICE AUXILIARY
CANCER ASSISTANCE PROGRAM**

Medication Reimbursement Form for Cancer Treatment



Patient's Name: _____
Responsible Party: _____
Address: _____
Phone: _____

This confirms that the following medication(s) is/are being prescribed for the treatment of cancer:

Name of Medication: _____

Stage of Treatment being received (Circle One):

Active Chemotherapy Treatment
Continuous/Follow-up Treatment

Physician Signature: _____ **Date** _____

Address: _____ **Phone** _____

Patient:

List each medication and attach pharmacy or insurance payment forms indicating out of pocket costs:

Medications:

Return to: Putnam County Homecare & Hospice
139 Court Street
Ottawa, OH 45875
Phone: 419-523-4449 Fax: 419-523-6328
(Next to the courthouse in Ottawa)

**Additional reimbursement forms
available at: www.pchh.net**

May call for more information at 419-523-5608, ext 238.

11/2011


A Service of
Putnam County HomeCare
And Hospice Auxiliary


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