Direct Member Reimbursement Form: Medications and Treatments

PAN grant recipients can submit approved expenses for reimbursement using this Direct Member Reimbursement (DMR) form.

You do not need to complete a DMR form if your healthcare provider or pharmacist has submitted or will submit a claim on your behalf.

Note: Providers and pharmacies cannot use this form to submit for payment. Please contact PAN for assistance if you would like payment to go to your provider or pharmacy. This form cannot be used to submit for travel or premium reimbursement. Please visit the PAN Foundation website (panfoundation.org) or contact us for information on travel and premium claims.

Instructions:

1. **Complete, sign and date this DMR form.** This form can be signed by either the patient or the individual completing the form on the patient's behalf.

2. If your expense is related to a **treatment or medication received from your pharmacy**, include one of the following:
   - **Itemized statement from your pharmacy**
   - **Prescription label (must include patient name, date of service, treatment or medication name, and patient responsibility/co-pay on the prescription label)**

3. If your expense is related to a **treatment or medication received at your physician's office or a hospital**, include:
   - **Explanation of Benefits (EOBs) from all applicable insurance companies**

4. **Fax or mail** the DMR form along with the required documentation to:

   - **Fax:** 844-726-4728

   - **Mailing Address:** PAN Foundation
     PO Box 2310
     Mt. Clemens, MI 48046

For complete requests, payment will be issued in the form of a paper check within 10 business days of receipt.

Questions? Contact PAN at 866-316-7263 Monday through Friday, 9 a.m. to 7 p.m. ET.

Patient Information

First Name: _____ Last Name: _____

Date of Birth (MM/DD/YYYY): _____ PAN ID Number: _____ Group Number: _____

Expense Information

Name of your medication or treatment: _____

Where did you receive your medication or treatment? (please check one)

◯ Physician Office ◯ Pharmacy ◯ Outpatient Hospital

◯ Other (Please describe): _____

Date(s) on which you received your medication or treatment (MM/DD/YYYY): _____

Requested reimbursement amount: _____

Person to whom PAN should send payment (please check one):

◯ Patient ◯ Caregiver/Parent/Guardian (Name:) _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Declaration

I attest and certify under penalty of law to the Patient Access Network Foundation that the information provided on this form is complete and accurate. I further understand that reported information may be verified by an audit as deemed necessary by the Foundation. I understand that assistance will terminate if the Foundation becomes aware of any fraudulent activity relating to the assistance provided by the Foundation. I understand that assistance may be limited to the terms and conditions established by the Foundation and that the Foundation reserves the right at any time, or for any reason, and without notice to (i) modify this form, (ii) modify or discontinue any or all of the programs and the related eligibility criteria, or (iii) terminate assistance.

I authorize the Foundation and its employees, third party administrators, agents and other representatives to obtain information from my healthcare providers, insurance coverage information from my employer or insurance company(ies) as necessary to complete the reimbursement process or to verify the accuracy of any information provided with this form.

Signature _____

Date _____

REMINDER: Did you attach the required expense documentation?