PAN Foundation

Direct Member Reimbursement Form: Medications and Treatments

PAN grant recipients can submit covered expenses for reimbursement using this Direct Member Reimbursement (DMR)form and proof of purchase. This form cannot be used to submit for travel or premium reimbursement. Please visit the PAN Foundation website at panfoundation.org/contact/ to send an inquiry for travel and premium claims.

Note: Providers and pharmacies cannot use this form to submit for payment.

Instructions:

1. **Please complete all fields, sign and date this DMR form.** This form can be signed by either the patient or the patient caregiver completing the form on the patient's behalf.

2. **Expenses related to medication or supplies, must include one of the following:**
   - EOB direct from the insurance carrier(s) must include: Insurance Carrier Name, Insurance Carrier Logo, Insurance Carrier Contact Information, DOS, Procedure/NDC, Allowable Insurance Amount, Amount Paid by the Insurance and Copay Amount due.
   - Prescription receipt label must include: Pharmacy Name and Address, Pharmacy Phone Number, Medication Name, Dosage, Provider, Directions, Pharmacist Initials, Date of Service, Refills, Patient Name, Patient Address, Prescription number, Quantity Dispensed, Expiration Date, Copay Amount Due, Prescriber, Insurance Carrier and Educational Support Documentation.
   - Photograph of the prescription label must include: Pharmacy Name and Address, Pharmacy Phone Number, Medication Name, Dosage, Provider, Directions, Pharmacist Initial, Date of Service, Refills, Patient Name, Patient Address, Prescription number, Quantity Dispensed, Copay Amount Due, Expiration Date and Prescriber.

3. **Proof of Payment is required for expenses, must include one of the following:**
   - Register receipt showing amount and pharmacy transaction number, transaction date, pharmacy name, pharmacy address and phone number.

4. **Fax, mail, or submit** the DMR form online along with the required documentation to:
   - **Fax:** 844-726-4728
   - **Mailing Address:** PAN Foundation, PO Box 25946, Overland Park, KS 66225
   - **Web via Portal:** https://www.panapply.org
     Note: You must be logged in to the portal to submit via portal. If you need assistance setting up your portal account, view our step-by-step guides online at https://www.panfoundation.org/guides

Payment made payable to the patient will be issued in the form of a paper check within 10 business days of receipt of completed forms.
Questions? Contact PAN at 866-316-7263, Monday through Friday, 9 a.m. to 5:30 p.m. ET.

REMINDER: Did you attach the required expense documentation?

PAN Foundation

* Indicates a required field

Patient Information

First Name*:________________ Last Name*: ________________

Date of Birth* (MM/DD/YYYY):__________ PANIDNumber*: __________ GroupNumber*: __________

Patient Address:

Street Address*: ________________ Phone Number*: ________________

City*:________________ State*:________________ ZIP*: ________________

Name of your medication(s)*: ________________

Where did you receive your medication(s)?* (please check one)

☐ Physician Office

☐ Pharmacy (Pickup/Mail Order)

☐Outpatient (Facility/Hospital)

List of date(s) you received your medication(s) (MM/DD/YYYY)*: ________________

Total requested reimbursement amount*: ________________

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.

Patient Attestation:

☐ I agree with all attestations presented above.

Patient Signature*:________________ Date*: ________________

Caregiver Attestation:

☐ I am attesting that I have informed the patient of all the above information and that the patient agrees with it or that I have the authority to make decisions on behalf of the patient and that I agree to the above attestations on behalf of the patient.

Caregiver First Name*:________________ Caregiver Last Name*: ________________

Caregiver Signature*: ________________ Date*: ________________

REMINDER: Did you attach the required expense documentation?