PATIENT SERVICE FORM

Delta County Cancer Alliance
3430 Ludington Street
Escanaba, MI 49829
(906)786-0854

Patient Name:_____ Phone: (_____)_____

Date of Birth_____/_____/_____ Age:_____ Sex:_____

Address: _____

City:_____ Zip:_____ Delta County Resident? YES NO

Nearest Relative/Friend Contact: _____ Phone:(_____)_____

Primary Care Physician:_____ Phone:(_____)_____

Primary Care Physician Address:_____

Specialty Physician/Clinic/Hospital:_____ Phone:(_____)_____

Specialty Physician/Clinic/Hospital Address:_____

TO BE FILLED OUT BY PHYSICIAN

I certify that I am treating the above named person for_____ cancer treatment.
(Cancer Diagnosis)

Physician Signature: _____ Date: _____

Physician Name (please print):_____

Financial assistance is available for cancer related expenses only. Please submit transportation form with treatment dates and miles to and from your home to treatment center. Please submit copies of medical bills indicating balance NOT COVERED BY INSURANCE, MEDICARE OR MEDICAID. Please send copies of your bills, do not send originals, which should be kept for your files. All applications will be reviewed by chairperson. Once approved, your reimbursement will be mailed to you from the Delta County Cancer Alliance office.

Delta County Cancer Alliance
Patient Transportation Form

Patient Name:_____ **Phone:** (____)_____

Address:_____

City:_____ **Zip:**_____

Please complete one line for round trip mileage

	DATE	Treatment Center City/State	Total Trip Miles
1.	____/____/____	_____	_____
2.	____/____/____	_____	_____
3.	____/____/____	_____	_____
4.	____/____/____	_____	_____
5.	____/____/____	_____	_____
6.	____/____/____	_____	_____
7.	____/____/____	_____	_____
8.	____/____/____	_____	_____
9.	____/____/____	_____	_____
10.	____/____/____	_____	_____
11.	____/____/____	_____	_____
12.	____/____/____	_____	_____
13.	____/____/____	_____	_____
14.	____/____/____	_____	_____
15.	____/____/____	_____	_____

Reimbursement is .50 cents per mile

Combined total miles: _____

***Please attach COPY of lodging receipt for treatment stays only**